COPY

IDAHO DEPARTMENT OF
# HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

February 28, 2011

Heather Davis, Administrator
Home Again ICF
2311 Aruba Drive
Nampa, ID 83686

Provider #13G078

Dear Ms. Davis:

On **February 14, 2011**, a complaint survey was conducted at Home Again ICF. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00004927**

Allegation: Staff are not providing adequate supervision.

Findings: An unannounced on-site investigation was conducted from 2/7/11 - 2/14/11. During that time, observations, record review, and staff and individual interviews were conducted with the following results:

The facility's accident/injury records and investigation documents from 7/1/10 - 2/7/11 were reviewed.

- One investigation document, signed and dated by the Administrator 8/9/10, documented a staff member had broken line-of-sight supervision for the individual he was responsible for by allowing the individual to go into the back yard with other individuals and staff. The staff was counseled and re-trained.

- One investigation document, dated 2/4/11, stated an individual reported staff had not been supervising him in the community and he was able to engage in inappropriate sexual contact with another individual. The incident was investigated by the facility and the police. Neither found

the allegation to be valid.

Observations were conducted at the facility, on 2/7/11 and 2/8/11, for a cumulative 3 hours 34 minutes. During that time, appropriate numbers of staff were noted to be present to supervise individuals. Additionally, no individuals were noted to be unsupervised during observations.

Four individuals were selected for review. None of the individuals' records showed evidence of supervision needs not being meet.

The facility's community outing sheets were reviewed. All outings documented sufficient numbers of staff were present to provide supervision for individuals in the community. Additionally, the facility's as-worked schedules were reviewed from 11/1/10 - 1/31/11. The schedules documented sufficient numbers of staff present on all shifts to meet individuals' supervision needs.

Two individuals residing in the facility were interviewed, on 2/7/11 from 2:45 - 4:15 p.m. Neither individual reported incidents of staff not being present or providing supervision.

Eight direct care staff were interviewed, on 2/7/11 from 2:45 - 4:15 p.m. and 2/8/11 from 8:00 - 8:20 a.m. All 8 staff were able to state the supervision needs of the individuals residing at the facility. Further, all staff denied knowledge of individuals not having adequate supervision.

Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion:Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/srm

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**CERTIFIED MAIL: 7003 0500 0003 1966 8596**

February 28, 2011

Heather Davis, Administrator
Home Again ICF
2311 Aruba Drive
Nampa, ID 83686

RE: Home Again ICF, Provider #13G078

Dear Ms. Davis:

Based on the complaint survey completed at Home Again ICF on February 14, 2011, by our staff, we have determined that Home Again ICF is out of compliance with the Medicaid Intermediate Care Facility for People with Intellectial Disabilities (ICF/ID) Conditions of Participation on **Client Protections (42 CFR 483.420) and Client Behavior & Facility Practices (42 CFR 483.450).** To participate as a provider of services in the Medicaid program, an ICF/MR must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused these conditions to be unmet, substantially limit the capacity of Home Again ICF to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). A similar form indicates State Licensure deficiencies.

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Conditions of Participation referenced above by submitting a written Credible Allegation of Compliance/Plan of Correction.

**It is important that your Credible Allegation/Plan of Correction address each deficiency in the following manner**:

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient

practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed.

Sign and date the form(s) in the space provided at the bottom of the first page.

**Such correetions must be achieved and compliance verified by this office, before March 30, 2011. To allow time for a revisit to verify corrections prior to that date, it is important that the completion dates on your Credible Allegation/Plan of Correction show compliance no later than March 18, 2011.**

Please complete your Allegation of Compliance/Plans of Correction and submit to this office by **March 10, 2011**.

Failure to correct the deficiencies and achieve compliance will result in our recommending that the Medicaid Agency terminate your approval to participate in the Medicaid Program. If you fail to notify us, we will assume you have not corrected.

Also, pursuant to the provisions of IDAPA 16.03.11.320.04, Home Again ICF ICF/ID is being issued a Provisional Intermediate Care Facility for People with Intellectial Disabilities license. The license is enclosed and is effective February 14, 2011, through June 14, 2011. The conditions of the Provisional License are as follows:

1. Post the provisional license.

2. Correct all cited deficiencies and maintain compliance.

Please be aware that failure to comply with the conditions of the provisional license may result in further action being taken against the facility's license pursuant to IDAPA 16.03.11.350.

Be advised, that, consistent with IDAPA 16.05.03.300, you are entitled to request an administrative review regarding the issuance of the provisional license. To be entitled to an administrative review, you must submit a written request by **March 25, 2011**. The request must state the grounds for the facility's contention of the issuance of the provisional license. You should include any documentation or additional evidence you wish to have reviewed as part of the administrative review.

Your written request for administrative review should be addressed to:

Randy May, Deputy Administrator
Division of Medicaid -- DHW
PO Box 83720
Boise, ID 83720-0036
Phone: (208)364-1804
Fax: (208)364-1811

If you fail to submit a timely request for administrative review, the Department of Health and Welfare's decision to issue the provisional license becomes final. Please note that issues, which are not raised at an administrative review, may not be later raised at higher level hearings (IDAPA 16.05.03.301).

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by March 10, 2011. If a request for informal dispute resolution is received after March 10, 2011 the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

We urge you to begin correction immediately. If yo0u have any questions regarding this letter or the enclosed reports, please contact me at (208)334-6626.

Sincerely,

Michael A Case, LSW

MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/srm
Enclosures

IDAHO DEPARTMENT OF
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February 28, 2011

Heather Davis, Administrator
Home Again ICF
2311 Aruba Drive
Nampa, ID 83686

Provider #13G078

Dear Ms. Davis:

On **February 14, 2011**, a complaint survey was conducted at Home Again Icf. The complaint allegations, findings, and conclusions are as follows:

**Complaint #ID00004937**

Allegation #1: Individuals' guardians are not provided with sufficient or requested information.

Findings #1: An unannounced on-site investigation was conducted from 2/7/11 - 2/14/11. During that time, observations, record review, and staff and guardian interviews were conducted with the following results:

The facility's accident/injury records and investigation documents from 7/1/10 - 2/7/11 were reviewed. Three of the investigation documents did not include documentation the individuals' guardians had been notified of the events or investigations.

Two guardians were interviewed, on 2/10/11 and 2/14/11. One guardian stated the facility provided them with information as requested. The second guardian stated communication with the facility had been a problem and they had not been receiving the information they wanted. However, the guardian stated they had recently spoken with the facility to address the issue. Additionally, the guardian stated they had received requested information from an individual's counselor without realizing the counselor was also a contracted employee of the facility and acting on behalf of the facility.

The Administrator was interviewed, on 2/11/11 from 10:30 a.m. - 12:25 p.m. The Administrator stated the facility did make contact with guardians to notify of significant events, but the notifications were not being documented.

it could not be substantiated guardians were not being provided with information as requested. Therefore, due to a lack of sufficient information the allegation was unsubstantiated.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Individuals behavioral data is not accurately reported to psychiatric providers.

Findings #2: An unannounced on-site investigation was conducted from 2/7/11 - 2/14/11. During that time, record review and staff interviews were conducted with the following results:

Four individuals were selected for review. All 4 individuals' records included a sheet, titled Behavioral Tally Data, that listed categories of maladaptive behaviors and listed a number following each category. Each sheet contained behavioral data for a month. No additional data (i.e. narrative data, specific incidents, etc.) was included on the Behavioral Tally Data sheets.

During an interview on 2/11/11 from 2:50 - 4:35 p.m., the Assistant Qualified Mental Retardation Professional (AQMRP) and the Qualified Mental Retardation Professional (QMRP) both stated the AQMRP completed the tally sheets after reviewing individuals' behavior data. The AQMRP created the categories based upon the information listed in individuals' behavior data. The QMRP stated the Behavioral Tally Data was sent with individuals to their psychiatric appointments where decisions related to medication adjustments were made. The QMRP stated no additional information was compiled and sent with individuals to psychiatric appointments. The QMRP or AQMRP did not attend individuals psychiatric appointments.

The Administrator, who was present during the interview with the QMRP and AQMRP, stated the facility's Licensed Practical Nurse (LPN) took the information and the individuals to psychiatric appointments.

During a telephone interview on 2/14/11 from 8:53 - 9:04 a.m., the facility's LPN stated she took the tally information to the psychiatric appointments. The LPN stated medication adjustments were based upon that tally information and any anecdotal information she may have from speaking with the one of the facility's AQMRPs and the Resident Services Manager (the facility's office manager). The LPN stated she sometimes received anecdotal information from the Administrator or QMRP, but stated she did not take specific information related to individuals' behaviors to the appointments.

The facility did not provide sufficient information to the psychiatric provider related to individuals' maladaptive behavior on which to base medication adjustment decisions. Therefore, the allegation was substantiated and deficient practice was cited at W159 and W252.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #3: Individuals are over medicated.

Findings #3: An unannounced on-site investigation was conducted from 2/7/11 - 2/14/11. During that time, observations, record review, and guardian interviews were conducted with the following results:

Observations were conducted at the facility, on 2/7/11 and 2/8/11, for a cumulative 3 hours 34 minutes. During that time, individuals were noted to be active and engaged in routine activities. There was no observable evidence that individuals were over medicated (i.e., individuals were not lethargic, sleeping, etc.).

Two guardians were interviewed, on 2/10/11 and 2/14/11. One guardian stated they had no concerns regarding the medications given to the individual, and stated they were kept informed of all medication changes. The second guardian did not express concerns about the individuals medications.

Four individuals were selected for review. All 4 individuals' records documented the individuals received behavior modifying medications. However, there was no documentation that indicated individuals were overmedicated. Additionally, one individuals record documented behavior modifying drugs had been reduced and certain drugs eliminated.

Therefore, due to a lack of sufficient information the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Individuals' appointments are cancelled due to a lack of qualified staff and guardians are not notified of the cancellations.

Findings #4: An unannounced on-site investigation was conducted from 2/7/11 - 2/14/11. During that time, record review and staff and guardian interviews were conducted with the following results:

The facility's appointment calendar was reviewed from 11/1/10 - 2/7/11. The calendar documented the following:

- Dental appointment for individuals had been cancelled on 12/15/10 and 12/28/10. During an interview on 2/11/11 from 10:30 a.m. - 12:25 p.m., the Administrator stated the appointments had been cancelled by the dental office. The appointments were later rescheduled.

- A Dermatologist appointment for an individual had been cancelled on 11/1/10. During an interview on 2/11/11, from 10:30 a.m. - 12:25 p.m., the Administrator stated the appointment had been cancelled at the dermatologists request and had been rescheduled 12/21/10.

- A counseling appointment for an individual had been cancelled on 12/14/10. During an interview on 2/11/11, from 10:30 a.m. - 12:25 p.m., the Administrator stated the appointment had been cancelled at the counselors request and had been rescheduled for 1/11/11.

- An individuals psychiatric appointment had been cancelled on 1/6/11. During an interview on 2/11/11 from 10:30 a.m. - 12:25 p.m., the Administrator stated the appointment had been set by the individual's mother who was not the custodial guardian. The Administrator stated the facility was made aware of the appointment after the fact, and that the facility's nurse had a conflicting appointment and could not attend. Given the facility needed to attend the appointment with the individual and the individual's mother did not have the authority to make the appointment, the appointment was cancelled and rescheduled.

Two guardians were interviewed on 2/10/11 and 2/14/11. One guardian stated she was not aware of the individual's appointments; however, she did not request to be informed. The guardian stated she did not have concerns with regards to the individual's appointments.

The second guardian stated an appointment had been made by an individual's mother who was not the custodial guardian. The guardian stated she was not aware the individual's mother was unable to make appointments without speaking with the facility first. The guardian stated she had met with the facility and the concern had been resolved.

The facility's records did document individuals' appointments had been cancelled. However, the cancelations were at the request of the service provider or for reasonable causes. Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208)

334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/srm

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 13G078 | A. BUILDING _____ B. WING _____ | C 02/14/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HOME AGAIN ICF | 2311 ARUBA DRIVE NAMPA, ID 83686 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| W 000 | INITIAL COMMENTS<br><br>The following deficiencies were cited during the complaint survey.<br><br>The survey was conducted by:<br>Michael Case, LSW, QMRP, Team Leader<br>Barbara Dern, QMRP<br><br>Common abbreviations/symbols used in this report are:<br>ABC - Antecedent, Behavior, Consequence<br>ADHD - Attention Deficit Hyperactive Disorder<br>AOD - Administrator On Duty<br>AQMRP - Assistant Qualified Mental Retardation Professional<br>CPI - Crisis Prevention Intervention - a behavioral intervention system which includes physical restraint.<br>HRC - Human Rights Committee<br>IDT - Interdisciplinary Team<br>IPP - Individual Program Plan<br>LPN - Licensed Practical Nurse<br>MAR - Medication Administration Record<br>NOS - Not Otherwise Specified<br>ODD - Oppositional Defiant Disorder<br>PBSP - Positive Behavior Support Plan<br>PRN - As Needed<br>PTSD - Post Traumatic Stress Disorder<br>QMRP - Qualified Mental Retardation Professional<br>RN - Registered Nurse | W 000 | for all corrections see Plan of Corrections Attached.<br><br>RECEIVED<br>MAR 0 9 2011<br>FACILITY STANDARDS | |
| W 122 | 483.420 CLIENT PROTECTIONS<br><br>The facility must ensure that specific client protections requirements are met.<br><br>This CONDITION is not met as evidenced by: | W 122 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Admin — (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| W 122 | Continued From page 1<br>Based on review of the facility's policies and procedures, suicide assessment forms, investigations, record review, and staff interviews it was determined the facility failed to provide the necessary client protections and ensure steps were taken to protect an individual during suicidal ideation, and failed to adequately implement policies related to abuse, neglect, and/or mistreatment. These failures resulted in a lack of effective systems to prevent neglect of an individual's assessment and monitoring needs following suicidal ideation and gestures and constituted serious and immediate jeopardy to the health and safety of an individual. Additionally, these failures resulted in a lack of immediate administrator notification, thorough investigation of allegations, and insufficient corrective action. The findings include:<br><br>1. Refer to W149 as it relates to the facility's failure to adequately implement policies necessary to prevent neglect of an individual's assessment and monitoring needs following suicidal ideation, and to protect individuals from abuse, neglect, and/or mistreatment. | W 122 | | |
| W 149 | 483.420(d)(1) STAFF TREATMENT OF CLIENTS<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.<br><br>This STANDARD is not met as evidenced by:<br>Based on review of the facility's policies and procedures for suicide, policies and procedures for abuse, review of suicide assessment forms, review of investigations, and staff interviews it was determined the facility failed to adequately | W 149 | | |

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| W 149 | Continued From page 2<br>implement policies necessary to prevent neglect of individuals' assessment and monitoring needs following suicidal ideation and protect individuals from abuse, neglect and/or mistreatment. That failure directly impacted 5 of 8 individuals (Individuals #1, #2, #5, #6, and #8), and had the potential to impact all individuals who engaged in suicidal ideation, or for whom abuse allegations were made. This resulted in the potential for individuals to be unprotected from abuse, neglect and/or mistreatment, to be insufficiently assessed and monitored for suicidal ideation, and resulted in one individual being placed in immediate jeopardy. The findings include:<br><br>1. The facility's Suicide Policy and Procedure, dated 1/11/10, stated "All residents who have verbalized suicide ideation, or acted in a way that presents an immediate and/or serious threat to themselves will be provided close observation, careful assessment, and a protective environment by direct care staff (DCS), QMRP, nursing staff, and other members of the IDT until the IDT has determined that the resident no longer presents a threat to themselves."<br><br>The Policy stated "If a patient verbalizes suicide ideation or demonstrates an immediate and/or serious threat to himself/herself, the QMRP, nursing staff, Administrator/AOD, and clinical social worker shall be notified immediately. The QMRP, Nursing staff, clinical social worker, or Administrator/AOD will determine if the resident has any high risk factors for suicide by using the Guidelines for Suicide Assessment and Action and the Scales of Suicide Ideation forms."<br><br>The Policy further stated "A direct care staff member shall remain with the resident and assist | W 149 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| HOME AGAIN ICF | 2311 ARUBA DRIVE NAMPA, ID 83686 |

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| W 149 | Continued From page 3<br>the nursing staff, QMRP, or psychologist to complete the scales of suicide ideation form over the phone if they are unable to come immediately to the facility."<br><br>Attached to the Policy was a form titled "Guidelines for Suicide Assessment and Action." The form included a list of instructions regarding the completion of the Scale of Suicide Ideation.<br><br>Also attached to the Policy was a form titled "Scale of Suicide Ideation" by A. Beck, M. Kovacs, and A. Weissman, also known as the Beck Scale of Suicide Ideation.<br><br>The Scale of Suicide Ideation form stated it was to be completed by the QMRP or nursing staff. The form consisted of the following 19 categories:<br>- Wish to live<br>- Wish to die<br>- Reasons for living/dying<br>- Desire to make active suicide attempt<br>- Passive suicidal desire<br>- Time dimension: Duration of suicide ideation/wish<br>- Time dimension: Frequency of suicide (unexplained)<br>- Attitude toward ideation/wish<br>- Control over suicidal action/acting out wish<br>- Deterrents to active attempt<br>- Reason for contemplated attempt<br>- Method: Specificity/planning of contemplated action<br>- Method: Availability/opportunity for contemplated attempt<br>- Sense of "capability" to carry out attempt<br>- Expectancy or anticipation of actual attempt<br>- Actual preparation for contemplated attempt<br>- Suicide note | W 149 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| HOME AGAIN ICF | 2311 ARUBA DRIVE NAMPA, ID 83686 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| W 149 | Continued From page 4<br>- Final acts in anticipation of death<br>- Deception or concealment of contemplated suicide<br><br>Each section was scored from 0 to 2, with 0 indicating a weak association in each category and 2 a moderate to strong association. The Guidelines for Suicide Assessment and Action stated the person completing the Scale was to use their "own skills" to reword the questions to obtain answers from the individual being assessed, and stated the person completing the form could ask staff for additional information. The form provided additional space for narrative notes.<br><br>The publishers of the Beck Scales, www.beckscales.com, describe the form as a "starting point" for assessment. The form did not provide sufficient information in and of itself to determine an individuals risk for suicide, but provided initial information to be used with the professional judgement of a practitioner trained in suicide assessment.<br><br>During the entrance conference on 2/7/11 at 10:35 a.m., the Administrator provided the following completed Scale of Suicide Ideation forms:<br><br>- 7/1/10 at 12:00 p.m. for Individual #2. The form was completed by Direct Care Staff E and score "0."<br><br>- 10/3/10 at 7:30 p.m. for Individual #2. The form was completed by Direct Care Staff B and score "1."<br><br>- 1/9/11 at 11:30 a.m. for Individual #5. The form | W 149 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| W 149 | Continued From page 5<br>was completed by Direct Care Staff C and scored "5."<br><br>- 1/19/11 at 7:15 p.m. for Individual #1. The form was completed by Direct Care Staff B and scored "0."<br><br>- 1/21/11 at 11:00 p.m. for Individual #5. The form was completed by Direct Care Staff D and scored "4."<br><br>None of the forms documented the QMRP, nursing staff, Administrator/AOD, or Clinical Social Worker had been notified or participated in the completion of the assessment as per the facility's policy. Additionally, none of the forms documented nursing staff, the QMRP, or the psychologist completed the forms over the telephone with the assistance of direct care staff.<br><br>During an interview on 2/8/11 from 11:25 a.m. - 1:20 p.m., the Administrator stated there was no additional documentation regarding individuals' suicidal ideation, and stated the facility's suicide policy had not been followed. The Administrator stated she had no specialized training regarding suicide assessment, but had been trained by the facility's Clinical Social Worker to complete the Scale of Suicide Ideation form. The Administrator stated she had then trained direct care staff to complete the form. The Administrator stated she did not know if the RN had received specialized training for suicide assessment.<br><br>The Administrator did not possess the necessary qualifications and training to adequately assess individuals' suicidal risk.<br><br>During an interview on 2/9/11 from 9:37 - 9:41 | W 149 | | |

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| W 149 | Continued From page 6<br>a.m., Staff D stated she began working for the facility in 10/10. Staff D stated the Administrator had reviewed the facility's suicide policy with her briefly on the day she was hired, but stated it was a "blur." Staff D stated the suicide policy was reviewed again in a recent staff meeting. When asked about the Scale of Suicide Ideation form, Staff D stated she had not been trained on use of the form and was only aware of the form because she had seen someone else use it. Staff D stated she did not use the actual form when she gathered the information noted on Individual #5's 1/21/11 form, but filled the form in afterwards.<br><br>During an interview on 2/9/11 from 10:15 - 10:20 a.m., Staff E stated he had worked for the facility for approximately one year. Staff E stated he was trained on the facility's suicide policy and completion of Scale of Suicide Ideation form by the Administrator on the day he was hired. Staff E stated if a form was completed and the individual scored "0," no additional action needed to be taken.<br><br>During an interview on 2/9/11 from 11:00 - 11:05 a.m., Staff C stated he had worked for the facility for 3 months. Staff C stated he had been trained on the facility's suicide policy and completion of the Scale of Suicide Ideation form by one of the facility's AQMRPs. Staff C stated he had received no additional training with regards to suicidal ideation or assessment.<br><br>Attempts were made to contact Staff B on 2/9/11, but Staff B no longer worked for the facility.<br><br>Without sufficient training or expertise in assessment of suicidal ideation, it would not be possible for direct care staff to adequately assess | W 149 | | |

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| W 149 | Continued From page 7<br>individuals' risk following threats of suicide by completion of the Scale of Suicide Ideation form without input from a qualified professional trained in suicide assessment.<br><br>During a telephone interview on 2/8/11 from 7:10 - 7:18 p.m., the QMRP stated the Scale of Suicide Ideation form was to be completed by whatever direct care staff was working with the individual who made the threat. The QMRP stated he felt, with the use of the form, direct care staff could make a determination that an individual was not at risk of suicide. When asked about staff training on completion of the form, the QMRP stated staff were shown how to complete the form and the protocol was attached to the front of the form. When asked if the protocol referred to was the Guidelines for Suicide Assessment and Action, the QMRP stated "yes."<br><br>During a follow up interview on 2/11/11 from 2:50 - 4:35 p.m., the QMRP stated he had been trained to fill out the Scale of Suicide Ideation form by the Administrator when he was hired, but stated he had not received specialized training regarding suicidal ideation or risk assessment either from the facility or through outside sources.<br><br>The QMRP did not possess the necessary qualifications and training to adequately assess individuals' suicidal risk.<br><br>During a telephone interview on 2/8/11 from 8:10 - 8:45 p.m., the Clinical Social Worker stated she had provided training to staff when the facility first opened in September or October of 2009. The Clinical Social Worker stated she had not provided any additional training to the facility, including any training to the facility's current | W 149 | | |

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| W 149 | Continued From page 8<br>QMRP, RN, or LPN. The Clinical Social Worker stated she was at the facility almost every week, but had not been asked to review any Scale of Suicide Ideation forms and had never been called when any forms had been completed. The Clinical Social Worker stated she did not feel staff would be sufficiently trained to make determinations of risk based upon the Scale of Suicide Ideation forms alone. The Clinical Social Worker stated she was not aware of anyone else employed by the facility that had been trained to make a clinical assessments regarding suicidal ideation and risk.<br><br>Record review was conducted at the facility on 2/9/11 for Individuals #1 - #4. Individual #2's 5/10 IPP stated he was a 13 year old male whose diagnoses included bipolar mixed with psychotic features, ADHD, mild mental retardation, and mood disorder.<br><br>Individual #2's record included an e-mail from his school, dated 12/10/10, that stated he had a "rough week" and "threatened self-harm on two separate occasions." The e-mail stated the worst of the two incidents took place on 12/10/10 where Individual #2 began "threatening that he was going to kill himself - he started to remove his shoe laces - we removed his shoes, he continued this process removing each piece of clothing attempting to wrap it around his neck - he had his thermal pants wrapped around his neck several times and was pulling them tighter - we removed them - he ended up in the nude in the quiet room..."<br><br>The e-mail included a response from the Administrator to the school, dated 12/13/10, which stated "the holiday time is very hard for | W 149 | | |

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| W 149 | Continued From page 9<br>[Individual #2] because he can't be with his family...We have seen him struggle at home as well...I think he is just really sad."<br><br>Individual #2's record did not contain any additional documentation that he was put on a suicide watch when he returned home from school, that additional assessments were completed by a qualified professional, or that plans were implemented to ensure his safety during future episodes of suicidal ideation or behavior. Additionally, review of Individual #2's nursing and psychiatric notes, from 7/1/10 - 2/9/11, did not include documentation that the psychiatrist or counselor had been notified of the events of 12/10/10.<br><br>Further, Individual #2's record included a document titled "ICF/MR Level of Care Risk Assessment," dated 4/14/10, which stated he had threatened suicide on various occasions when living at his two previous placements and since admission to the facility on 1/27/10. However, Individual #2's 5/10 IPP and attached Positive Behavior Support Plan did not include objectives or directions to staff related to suicidal ideation or attempts.<br><br>During an interview on 2/9/11 from 3:50 - 4:05 p.m., the Administrator stated Individual #2 had not been placed on any additional suicidal precautions related to the incident at school. The Administrator stated Individual #2's plans did not include information regarding suicidal ideation or attempts.<br><br>In sum, the facility utilized a Scale of Suicide Ideation form to assess individuals who engaged in suicidal ideation or attempts. Per the facility | W 149 | | |

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| W 149 | Continued From page 10<br>policy, the QMRP, Nursing staff, Clinical Social Worker, or Administrator/AOD were to determine if an individual had high risk factors for suicide. However, per interview with the Administrator and Clinical Social Worker, the facility's Administrator, QMRP, and direct care staff did not have sufficient training to implement the facility's policy and adequately assess individuals' risk.<br><br>Additionally, Individual #2's assessments indicated he had made multiple suicide threats but had no objectives or plans to address those threats.<br><br>Further, on 12/10/10 Individual #2 made significant suicidal gestures that included wrapping clothing tightly around his neck. There was no action taken by the facility with regards to the incident, no plans to address future attempts or threats, and no documentation the incident had been reported to Individual #2's psychiatrist or counselor.<br><br>The facility failed to provide sufficient systems, staff training, and program development necessary to keep Individual #2 safe when he engaged in suicidal ideation.<br><br>Note: The facility provided an immediate plan of correction, on 2/9/11 at 5:45 p.m., which stated any individual that voiced suicidal ideation or made any type of gesture would be immediately placed on suicide watch with a 1-on-1 arm's length staff, a Scale of Suicide Ideation form would be completed by trained staff and the results immediately called to the facility's Licensed Clinical Social Worker (LCSW), the LCSW would gather additional information as needed and provide instructions to staff including | W 149 | | |

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| W 149 | Continued From page 11<br>items to remove if needed, and the individual would remain on suicide watch until the LCSW deemed the individual safe. All staff were to be trained on the new procedures prior to working with individuals residing at the facility.<br><br>Based on staff interviews conducted on 2/10/11 at 9:00 a.m., the immediate jeopardy was abated.<br><br>2. Refer to W153 as it relates to the facility's failure to ensure all allegations of abuse were immediately reported to the administrator.<br><br>3. Refer to W154 as it relates to the facility's failure to ensure all allegations of abuse, neglect and mistreatment were thoroughly investigated.<br><br>4. Refer to W157 as it relates to the facility's failure to ensure sufficient corrective action was implemented to prevent recurrence of late administrator notification. | W 149 | | |
| W 153 | 483.420(d)(2) STAFF TREATMENT OF CLIENTS<br><br>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.<br><br>This STANDARD is not met as evidenced by:<br>Based on review of investigations, review of the facility's abuse policy, and staff interviews it was determined the facility failed to ensure all allegations of abuse were immediately reported to the administrator for 2 of 5 individuals (Individuals #5 and #6) for whom abuse was alleged. This | W 153 | | |

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| W 153 | Continued From page 12<br>resulted in the potential for on-going abuse to occur. Findings include:<br><br>1. The facility's Abuse Policy, undated, stated abuse was defined as "the ill-treatment, violation, revilement, exploitation and/or otherwise disregard of the individual, whether purposeful or due to carelessness, inattentiveness, or omission of the perpetrator." The Policy further stated any staff member who witnessed or received reports of abuse were to take immediate action to protect the individual and notify the staff member in charge immediately. The Policy stated the staff member in charge was to immediately notify the QMRP and Administrator.<br><br>The Policy was not implemented as follows:<br><br>a. A Client Significant Event Report, dated 8/18/10, documented Individual #6 had reported to staff her brother's father had "touched her in bad places." Individual #6 made the disclosure to staff on 8/6/10. However the staff did not report the incident to the staff in charge until 8/18/10, at which time the Administrator was also notified.<br><br>During an interview on 2/8/11 from 11:25 a.m. - 1:20 p.m., the Administrator stated the late notification had not been identified as an issue or addressed by the facility.<br><br>b. An Investigation, undated but signed by the AQMRP 8/20/10, documented Individual #5 made allegations, on 8/17/10, that a staff was starring at her and made her feel uncomfortable. The Investigation documented the Administrator was not notified until 8/18/10.<br><br>During an interview on 2/8/11 from 11:25 a.m. - | W 153 | | |

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| W 153 | Continued From page 13<br>1:20 p.m., the Administrator stated the late notification had not been identified as an issue or addressed by the facility.<br><br>The facility failed to ensure all allegations of abuse were immediately reported to the Administrator. | W 153 | | |
| W 154 | 483.420(d)(3) STAFF TREATMENT OF CLIENTS<br><br>The facility must have evidence that all alleged violations are thoroughly investigated.<br><br>This STANDARD is not met as evidenced by:<br>Based on review of the facility's abuse policy, review of investigations and staff interview, it was determined the facility failed to ensure all allegations of abuse were thoroughly investigated. This directly impacted 4 of 5 individuals (Individuals #1, #2, #5 and #8) for whom alleged abuse was investigated and had the potential to impact all individuals for whom allegations of abuse, neglect or mistreatment were alleged. This resulted in an absence of appropriate investigation and follow up to the incidents. The findings include:<br><br>1. The facility's Abuse Policy, undated, stated "All incidents of unknown origin and allegations of mistreatment, neglect, threats, or abuse shall be thoroughly investigated by the IDT..."<br><br>During the entrance conference on 2/7/11 at 10:35 a.m., the Administrator was asked for all investigations related to allegations of abuse, neglect, or mistreatment conducted from 7/1/10 - 2/7/11. The Administrator provided several documents to the survey team as completed | W 154 | | |

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| W 154 | Continued From page 14<br>investigations.<br><br>The documents provided were not of a consistent format (i.e., some were labeled investigations, some written reprimands, some untitled, etc.), and did not contain consistent information regarding who completed the investigation, the methods used to complete the investigation, time frames within which the investigation was completed, or consistent documentation of the information gathered during the investigation process.<br><br>During an interview on 2/8/11 from 11:25 a.m. - 1:20 p.m., the Administrator stated the facility did not have a standardized format for completing investigations. The Administrator stated she was not sure how much detailed information could be included in an investigation document.<br><br>The facility's system for completing investigations was not sufficiently developed and implemented to ensure thorough and comprehensive investigations were completed. Additionally, the documents provided as completed investigations did not contain sufficient information to indicate thorough investigations had been conducted as follows:<br><br>a. A single page document titled "Neglect Investigation," dated 1/24/11, stated a staff had been acting as charge staff while on probation, which was not allowed by the facility. During that time, an unnamed individual residing at the facility threatened suicide and had a specific plan. The staff failed to put the individual on suicide watch to ensure her safety, and failed to complete a suicide scale according to facility policy. The staff allegedly told a coworker she would "deal with it in | W 154 | | |

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| W 154 | Continued From page 15<br>the morning."<br><br>The document was written in the form of a staff written reprimand and did not contain documentation of a thorough investigation including the name of the individual who threatened suicide, specific information regarding how the incident was discovered, or names and dates of staff or individuals interviewed, documentation of what was said during those interviews, or review of documentation/records (i.e., staffing during the alleged time, shift notes, ABC Forms, etc.) that could provide additional information regarding the situation.<br><br>During an interview on 2/8/11 from 11:25 a.m. - 1:20 p.m., the Administrator stated there was no additional documentation regarding the investigation. The Administrator stated she did not provide additional information related to specifics of the incident due to concerns of confidentiality.<br><br>b. A single page document, untitled and signed by the Administrator 8/9/10, stated a staff broke line of sight supervision of a individual residing at the facility. The form also stated the staff told another individual she had a "bad voice."<br><br>The document did not include information related to when the incidents took place, how they were discovered, or information related to staff and individual interviews.<br><br>During an interview on 2/8/11 from 11:25 a.m. - 1:20 p.m., the Administrator stated there was additional information regarding the incidents and indicated another document, titled "Final Written Reprimand," dated 12/1/10. | W 154 | | |

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| W 154 | Continued From page 16<br><br>The Final Written Reprimand stated the document was being presented to a staff "in lieu of a suspension without pay." The document stated the staff had previously been informed of work performance not meeting expectations. The document listed three specific incidents which included failure to provide adequate supervision to individuals residing at the facility (described as watching television while an individual went outside), unprofessional communication with the residents (using sarcasm and teasing), and violation of the company cell phone policy (repeatedly posting on a web-based community page with a cell phone over a 3 hour period).<br><br>However, the Final Written Reprimand did not include specific information related to each of the allegations such as individuals involved, dates and times of the alleged incidents, how the incidents were discovered, names and dates of staff interviewed, documentation of what was said during those interviews, or review of facility documentation that could provide additional information regarding the allegations.<br><br>Additionally, the Final Written Reprimand documented the staff had intimidated and sexually harassed a female coworker in front of individuals residing at the facility. However, there was no indication the incidents were investigated to ensure potential psychological abuse had not taken place with regard to the individuals residing at the facility.<br><br>During an interview on 2/8/11 from 11:25 a.m. - 1:20 p.m., the Administrator stated there was no additional information regarding the alleged incidents. The Administrator stated there was no | W 154 | | |

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| W 154 | Continued From page 17<br>documentation of a thorough investigation.<br><br>c. A single page document titled "[Staff Name] Abuse Investigation," dated 1/28/11, stated Individual #2 alleged a staff hit him with the back of their hand.<br><br>The "Investigation" section of the document stated interviews were conducted with Charge Staff and "other staff and residents." However, the document did not contain information related to who those individuals and staff were, dates and times they were interviewed, in what manner they were interviewed (i.e., individually or in a group), or documentation of what was said during the interviews. Additionally, the document did not indicate when the incident took place, if the incident, allegation, and interviews all took place on the date of the document, who the allegation was made to, or who conducted the investigation.<br><br>During an interview on 2/8/11 from 11:25 a.m. - 1:20 p.m., the Administrator stated the document needed to contain more specific information.<br><br>d. A single page document titled "[Individual #1] Investigation," dated 2/4/11, stated Individual #1 alleged he had been able to engage in inappropriate sexual behavior in a girls' locker room due to a lack of staff supervision.<br><br>The "Investigation" section of the document stated interviews had been conducted with direct care staff, other individuals residing at the facility, and all Charge Staff. However, the document did not contain specific information regarding names and dates of individuals and staff interviewed, documentation of what was said during the interviews, names and dates of individuals | W 154 | | |

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| W 154 | Continued From page 18<br>outside the facility that were interviewed, review of facility records to determine when and if the incident could have occurred, or documentation of who completed the investigation.<br><br>During an interview on 2/8/11 from 11:25 a.m. - 1:20 p.m., the Administrator stated there was no documentation of a thorough investigation.<br><br>e. A single page document titled "[Individual #5] Investigation," undated but signed by the AQMRP 8/20/10, included two sections of bullet point statements, one titled "[Individual #5's] Story" and the second titled "Staff's story." However, the document did not contain a specific allegation or documentation of who the allegation was against, but documented Individual #5 alleged a staff made her uncomfortable and was starring at her.<br><br>Additionally, the document did not include information related to who completed the investigation, how the investigation was completed, names and dates of individuals and staff interviewed, documentation of what was said during the interviews, or records that were reviewed.<br><br>During an interview on 2/8/11 from 11:25 a.m. - 1:20 p.m., the Administrator stated the document did not contain sufficient information to show a through investigation had been conducted.<br><br>f. A single page document titled "[Individual #8] Investigation," undated, stated Individual #8's father received a telephone call from Individual #8's school stating Individual #8 had been sent to school with wet clothing in his backpack on 2/2/11. | W 154 | | |

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| W 154 | Continued From page 19<br>The "Investigation" section of the document stated the facility's Residential Service Manager called the school and was informed by "the teacher" Individual #8 had come to school on two consecutive days with the same wet clothing in his backpack. The "Findings" section of the document stated the Residential Service Manager found the items were swim clothing from a swim outing on the weekend.<br><br>However, the document did not indicate the date and time the allegation was received, the names and dates of staff interviewed, documentation of what was said during the interviews, or review of facility records to indicate when and how the incident had occurred.<br><br>During an interview on 2/8/11 from 11:25 a.m. - 1:20 p.m., the Administrator stated the document did not contain sufficient detail.<br><br>g. An Incident Report Sheet, signed and dated by direct care staff on 8/26/10, stated Individual #8 had been found to have two bruises, one on each side of his face. The Incident Report Sheet stated the origins of the bruises were unknown. Hand-written notes, which appeared to be made by the staff completing the form, stated "multiple staff say they were self injurious when he gets in behavior." Attached to the back of the form was a single hand-written sheet, signed and dated by the Administrator on 8/28/10, which stated staff were retrained to restrain Individual #8 if he was hitting himself.<br><br>However, the document did not indicate who and how the incident was investigated, what staff or individuals were interviewed and by who, the outcome of those interviews, or review of records | W 154 | | |

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| W 154 | Continued From page 20<br>that would provide information about the incident.<br><br>During an interview on 2/8/11 from 11:25 a.m. - 1:20 p.m., the Administrator stated the document did not contain sufficient detail.<br><br>The facility failed to ensure all allegations of potential abuse, neglect, and mistreatment were thoroughly investigated. | W 154 | | |
| W 157 | 483.420(d)(4) STAFF TREATMENT OF CLIENTS<br><br>If the alleged violation is verified, appropriate corrective action must be taken.<br><br>This STANDARD is not met as evidenced by:<br>Based on review of investigations and staff interview, it was determined the facility failed to ensure appropriate corrective action was taken for 2 of 5 individuals (Individuals #5 and #6) for whom investigations were completed. This resulted in a lack of training with regards to immediate reporting of potential abuse, neglect, and mistreatment. The findings include:<br><br>1. The facility's Abuse Policy, undated, stated "...the IDT team shall meet within 5 days of the event to see what, if any other actions and changes need to be made to ensure that the abuse, threats, neglect, mistreatment, or injury will not happen again, and ensure the appropriate corrective action has been taken to prevent reoccurrence."<br><br>a. A Client Significant Event Report, dated 8/18/10, documented Individual #6 had reported to staff her brother's father had "touched her in bad places." Individual #6 made the disclosure to | W 157 | | |

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| W 157 | Continued From page 21<br>staff on 8/6/10. However, the staff did not report the incident to the staff in charge until 8/18/10, at which time the Administrator was also notified.<br><br>The document did not indicate that failure to immediately notify the Administrator had been identified as an issue, or that appropriate corrective action had been completed.<br><br>During an interview on 2/8/11 from 11:25 a.m. - 1:20 p.m., the Administrator stated the late notification had not been identified as an issue. The Administrator stated no corrective action (i.e., staff training regarding notification) was implemented to ensure repeat occurrences did not take place.<br><br>b. An Investigation, undated but signed by the AQMRP on 8/20/10, documented Individual #5 made allegations, on 8/17/10, that a staff was starring at her and made her feel uncomfortable. The Investigation documented the Administrator was not notified until 8/18/10.<br><br>The document did not indicate that failure to immediately notify the Administrator had been identified as an issue, or that appropriate corrective action had been completed.<br><br>During an interview on 2/8/11 from 11:25 a.m. - 1:20 p.m., the Administrator stated the late notification had not been identified as an issue. The Administrator stated no corrective action (i.e., staff training regarding notification) was implemented to ensure repeat occurrences did not take place.<br><br>The facility failed to ensure corrective action was taken for all concerns identified in Individual #5 | W 157 | | |

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| W 157 | Continued From page 22<br>and Individual #6's abuse investigations. | W 157 | | |
| W 159 | 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL<br><br>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interviews, it was determined the facility failed to ensure the QMRP provided sufficient monitoring and coordination for 4 of 4 individuals (Individuals #1 - #4) reviewed. That failure resulted in individuals not receiving the necessary assessments, objectives, and training required to meet their behavioral needs. The findings include:<br><br>1. Record review was conducted at the facility on 2/9/11 for Individuals #1 - #4. At that time, documentation of QMRP monitoring from 7/1/10 to 2/9/11 was reviewed.<br><br>a. Each record contained a form, titled QMRP Notes and IPP Objective Evaluation Sheet. The form documented the individuals' objectives and monthly implementation rates. The form did not include narrative documentation or information that would demonstrate QMRP monitoring or oversight regarding individuals' progress or coordination of services.<br><br>During an interview on 2/11/11 from 10:30 a.m. - 12:25 p.m., the Administrator stated additional documentation of QMRP oversight did not exist.<br><br>During an interview on 2/11/11 from 2:50 - 4:35 p.m., the QMRP was asked about the lack of | W 159 | | |

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| W 159 | Continued From page 23<br>identified monitoring and oversight. The QMRP stated he had intended to correct the issue.<br><br>b. Each record contained a form, titled Behavioral Tally Data, which listed general maladaptive behavioral categories. Each category included a number indicating total of behaviors for each month. However, the form did not include narrative documentation or information that would demonstrate QMRP monitoring or coordination of services with the psychiatric provider.<br><br>During an interview on 2/11/11 from 2:50 - 4:35 p.m., the AQMRP and QMRP both stated the AQMRP completed the tally sheets after reviewing individuals' ABC Forms. The QMRP stated he may or may not review the ABC Forms. The QMRP stated no additional information was compiled and sent with individuals to psychiatric appointments where medication adjustment decisions were made. The QMRP did not attend the psychiatric appointments.<br><br>c. The records did not contain documentation of data collection and monitoring for all objectives as follows:<br><br>- Individual #3's IPP included an objective for refusals defined as stating he would not engage in a task staff asked him to complete. Behavioral summary data or other documentation of QMRP monitoring of the objective could not be found in Individual #3's record.<br><br>- Individual #3's IPP included an objective for restlessness defined as difficulty falling asleep at night. Behavioral summary data or other documentation of QMRP monitoring of the objective could not be found in Individual #3's | W 159 | | |

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| W 159 | Continued From page 24<br>record.<br><br>- Individual #4's IPP included an objective for restlessness defined as becoming more awake and restless as it gets closer to night time. Behavioral summary data or other documentation of QMRP monitoring of the objective could not be found in Individual #4's record.<br><br>During an interview on 2/11/11 from 2:50 - 4:35 p.m., the QMRP stated monitoring of data collection was not sufficient.<br><br>2. Refer to W214 as it relates to the facility's failure to ensure the QMRP ensured behavioral assessments were comprehensive and accurately identified individuals' behavioral status and needs.<br><br>3. Refer to W227 as it relates to the facility's failure to ensure the QMRP ensured objectives were developed to meet individuals' needs.<br><br>4. Refer to W239 as it relates to the facility's failure to ensure the QMRP ensured appropriate replacement behaviors were identified and incorporated into individuals' behavior intervention programs.<br><br>5. Refer to W252 as it relates to the facility's failure to ensure the QMRP ensured data was collected sufficiently to determine the efficacy of individuals' intervention strategies.<br><br>6. Refer to W262 as it relates to the facility's failure to ensure the QMRP ensured restrictive interventions were not implemented prior to approval by the HRC. | W 159 | | |

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| W 159 | Continued From page 25<br>7. Refer to W263 as it relates to the facility's failure to ensure the QMRP ensured restrictive interventions were implemented only after guardian consent was obtained.<br><br>8. Refer to W278 as it relates to the facility's failure to ensure the QMRP ensured an individual's record included evidence of least restrictive or more positive techniques being utilized prior to the use of more restrictive techniques to manage behavior.<br><br>9. Refer to W303 as it relates to the facility's failure to ensure the QMRP ensured individuals' records documented a clear understanding of the events before, during, and after the use of restraint.<br><br>10. Refer to W312 as it relates to the facility's failure to ensure the QMRP ensured behavior modifying drugs were used only as a comprehensive part of individuals' IPPs that were directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed.<br><br>11. Refer to W313 as it relates to the facility's failure to ensure the QMRP ensured behavior modifying drugs were not used until the severity of an individual's behavior was shown to outweigh the associated risks of the drug. | W 159 | | |
| W 166 | 483.430(b)(1) PROFESSIONAL PROGRAM SERVICES<br><br>Professional program staff must work with paraprofessional, nonprofessional and other professional program staff who work with clients. | W 166 | | |

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| W 166 | Continued From page 26<br>This STANDARD is not met as evidenced by:<br>Based on review of facility policy, record review and staff interviews, it was determined the facility failed to ensure professional staff worked with other professionals, paraprofessionals, and direct care staff sufficiently to ensure the implementation and monitoring of services required. This directly impacted 3 of 3 individuals (Individuals #1, #2, and #5) who threatened suicide, and had potential to impact all individuals who experienced suicidal ideation. This resulted in a lack of thorough assessment and staff training in relation to suicidal ideation. The findings include:<br><br>1. The facility's Suicide Policy and Procedure, dated 1/11/10, stated "All residents who have verbalized suicide ideation, or acted in a way that presents an immediate and/or serious threat to themselves will be provided close observation, careful assessment, and a protective environment by direct care staff (DCS), QMRP, nursing staff, and other members of the IDT until the IDT has determined that the resident no longer presents a threat to themselves."<br><br>The Policy stated "If a patient verbalizes suicide ideation or demonstrates an immediate and/or serious threat to himself/herself, the QMRP, nursing staff, Administrator/AOD, and clinical social worker shall be notified immediately. The QMRP, Nursing staff, clinical social worker, or Administrator/AOD will determine if the resident has any high risk factors for suicide by using the Guidelines for Suicide Assessment and Action and the Scales of Suicide Ideation forms."<br><br>The Policy further stated "A direct care staff member shall remain with the resident and assist | W 166 | | |

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| W 166 | Continued From page 27<br>the nursing staff, QMRP, or psychologist to complete the scales of suicide ideation form over the phone if they are unable to come immediately to the facility."<br><br>During the entrance conference on 2/7/11 at 10:35 a.m., the Administrator provided the following completed Scale of Suicide Ideation forms:<br><br>- 7/1/10 at 12:00 p.m. for Individual #2. The form was completed by Direct Care Staff E.<br><br>- 10/3/10 at 7:30 p.m. for Individual #2. The form was completed by Direct Care Staff B.<br><br>- 1/9/11 at 11:30 a.m. for Individual #5. The form was completed by Direct Care Staff C.<br><br>- 1/19/11 at 7:15 p.m. for Individual #1. The form was completed by Direct Care Staff B.<br><br>- 1/21/11 at 11:00 p.m. for Individual #5. The form was completed by Direct Care Staff D.<br><br>None of the forms documented the QMRP, nursing staff, Administrator/AOD, or Clinical Social Worker had been notified or participated in the completion of the assessment as per the facility's policy. Additionally, none of the forms documented nursing staff, the QMRP, or the psychologist completed the forms over the telephone with the assistance of direct care staff.<br><br>During an interview on 2/9/11 from 9:37 - 9:41 a.m., Staff D stated she began working for the facility in 10/10. Staff D stated the Administrator had reviewed the facility's suicide policy with her briefly on the day she was hired, but stated it was | W 166 | | |

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| W 166 | Continued From page 28<br>a "blur." Staff D stated the suicide policy was reviewed again in a recent staff meeting. When asked about the Scale of Suicide Ideation form, Staff D stated she had not been trained on the use of the form and was only aware of the form because she had seen someone else use it. Staff D stated she did not use the actual form when she gathered the information noted on Individual #5's 1/21/11 form, but filled the form in afterwards.<br><br>During an interview on 2/9/11 from 10:15 - 10:20 a.m., Staff E stated he had worked for the facility for approximately one year. Staff E stated he was trained on the facility's suicide policy and completion of the Scale of Suicide Ideation form by the Administrator on the day he was hired. Staff E stated if a form was completed and the individual scored "0," no additional action needed to be taken.<br><br>During an interview on 2/9/11 from 11:00 - 11:05 a.m., Staff C stated he had worked for the facility for 3 months. Staff C stated he had been trained on the facility's suicide policy and completion of the Scale of Suicide Ideation form by one of the facility's AQMRPs. Staff C stated he had received no additional training with regards to suicidal ideation or assessment.<br><br>Attempts were made to contact Staff B on 2/9/11, but Staff B no longer worked for the facility.<br><br>Without sufficient training or expertise in assessment of suicidal ideation, it would not be possible for direct care staff to adequately assess individuals' risk following threats of suicide by completion of the Scale of Suicide Ideation form without input from a qualified professional trained | W 166 | | |

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| W 166 | Continued From page 29<br>in suicide assessment.<br><br>During an interview on 2/8/11 from 11:25 a.m. - 1:20 p.m., the Administrator stated there was no additional documentation regarding individuals' suicidal ideation, and stated the facility's suicide policy had not been followed. The Administrator stated she had no specialized training regarding suicide assessment, but had been trained by the facility's Clinical Social Worker to complete the Scale of Suicide Ideation form. The Administrator stated she had then trained direct care staff to complete the form. The Administrator stated she did not know if the RN had received specialized training for suicide assessment.<br><br>The Administrator did not possess the necessary qualifications and training to adequately assess individuals' suicidal risk.<br><br>During a telephone interview on 2/8/11 from 7:10 - 7:18 p.m., the QMRP stated the Scale of Suicide Ideation form was to be completed by whatever direct care staff was working with the individual who made the threat. The QMRP stated he felt, with the use of the form, direct care staff could make a determination that an individual was not at risk of suicide. When asked about staff training on completion of the form, the QMRP stated staff were shown how to complete the form and the protocol was attached to the front of the form.<br><br>During a follow up interview on 2/11/11 from 2:50 - 4:35 p.m., the QMRP stated he had been trained to fill out the Scale of Suicide Ideation form by the Administrator when he was hired, but stated he had not received specialized training regarding suicidal ideation or risk assessment | W 166 | | |

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| W 166 | Continued From page 30<br>either from the facility or through outside sources.<br><br>The QMRP did not possess the necessary qualifications and training to adequately assess individuals' suicidal risk.<br><br>During a telephone interview on 2/8/11 from 8:10 - 8:45 p.m., the Clinical Social Worker stated she provided training to staff when the facility first opened in September or October of 2009. The Clinical Social Worker stated she had not provided any additional training to the facility's paraprofessional, nonprofessional, or professional staff. The Clinical Social Worker stated she was at the facility almost every week, but had not been asked to review any Scale of Suicide Ideation forms and had never been called when any forms had been completed. The Clinical Social Worker stated she did not feel staff would be sufficiently trained to make determinations of risk based upon the Scale of Suicide Ideation forms alone. The Clinical Social Worker stated she was not aware of anyone else employed by the facility that had been trained to make a clinical assessments regarding suicidal ideation and risk.<br><br>The facility failed to ensure the Clinical Social Worker worked sufficiently with the facility's paraprofessional, nonprofessional, or professional staff to address individuals' suicidal ideation and gestures. | W 166 | | |
| W 214 | 483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN<br><br>The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. | W 214 | | |

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| W 214 | Continued From page 31<br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interviews, it was determined the facility failed to ensure behavioral assessments were completed for 4 of 4 individuals (Individuals #1 - #4) whose behavior assessments, IPPs, behavioral data and behavioral programs were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include:<br><br>1. Individual #1's record documented a 12 year old male diagnosed with mild mental retardation, ADHD, PTSD, and impulse control disorder. His undated IPP and 11/10 behavior assessment stated the following:<br><br>a. Individual #1's "Functional Behavioral Assessment" included the diagnoses of ADHD, PTSD, and impulse control disorder. The assessment also stated he engaged in task avoidance, verbal aggression/intimidation, physical intimidation, physical aggression, having tantrums/throwing fits, and property damage. However, there was no information related to the relationship of the diagnoses and the maladaptive behaviors Individual #1 displayed.<br><br>During an interview on 2/11/11 from 2:50 - 4:35 p.m., the Administrator stated Individual #1's psychiatric diagnosis information had not been used when completing the behavior assessment.<br><br>The facility failed to ensure the behavioral assessment included information as to how Individual #1's diagnoses contributed to eliciting and sustaining his maladaptive behaviors.<br><br>b. The "Affective Development" section of | W 214 | | |

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| W 214 | Continued From page 32<br>Individual #1's IPP included a diagnosis of ODD and stated "having been recently uprooted and placed into a new living environment [Individual #1] is generally defiant and angry towards other residents and staff." Additionally, the IPP included a "Service Object #2" which stated he "displays mal-adaptive behaviors associated with his mental illness that he requires weekly counseling to manage and reduce."<br><br>The diagnosis of ODD, the environmental factor of moving, and the behaviors associated with his mental illness were not identified in his behavioral assessment.<br><br>The facility failed to ensure the behavioral assessment included information as to how Individual #1's diagnosis of ODD, environmental factor of moving, and mental illness contributed to eliciting and sustaining his maladaptive behaviors.<br><br>c. Individual #1's IPP stated he received Guanfacine (an antihypertensive drug) 1 mg twice a day for aggression, Depakote (an anticonvulsant drug) 250 mg twice a day for aggression and Strattera (a central nervous system drug) 40 mg each morning for ADHD. Additionally, his 1/11 MAR stated he received topiramate (an anticonvulsant drug) 25 mg daily for PTSD. His "Functional Behavioral Assessment" did not include information related to the medications he was receiving for his aggression, his ADHD, or his PTSD.<br><br>During an interview on 2/11/11 from 2:50 - 4:35 p.m., the Administrator stated Individual #1's psychiatric medication information had not been used when completing the behavior assessment. | W 214 | | |

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| W 214 | Continued From page 33<br><br>The facility failed to ensure the behavioral assessment included information related to Individual #1's psychiatric medications and their impact on his maladaptive behaviors.<br><br>d. Individual #1's assessment stated he engaged in verbal aggression/intimidation (defined as yelling, swearing or making derogatory statements to staff or peers) to avoid tasks and to get what he wants. However the "Description of problem behavior #2" section of his IPP stated he "resorts to verbal assault on staff and others when he does not get what he wants an average of 3-4 times per day. His objective in this behavior ranges from attention seeking to trying to intimidate others." The function of Individual #1's verbal aggression was not consistently documented in his record.<br><br>During an interview on 2/11/11 from 2:50 - 4:35 p.m., the Administrator stated definitions and descriptions of behaviors were not consistent across records.<br><br>The facility failed to ensure the function of Individual #1's maladaptive behaviors were consistently documented.<br><br>e. Individual #1's assessment stated he engaged in tantrums/throwing fits (defined as throwing items, crying uncontrollably and falling to the ground) to avoid tasks. However, the "Description of problem behavior #5" section of his IPP stated "When [Individual #1] is told no by staff he will sometimes have a tantrum." The function of Individual #1's tantrums was not consistently documented in his record. | W 214 | | |

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| W 214 | Continued From page 34<br>The facility failed to ensure the function of Individual #1's maladaptive behaviors were consistently documented.<br><br>f. Individual #1's Behavioral Tally Data Sheets for 12/10 and 1/11 documented the maladaptive behavior of "Inappropriate sexual." However no information related to the behavior could be found on Individual #1's behavioral assessment.<br><br>During an interview on 2/11/11 from 2:50 - 4:35 p.m., the Administrator stated Individual #1's behavioral assessment needed to be revised to capture all pertinent information related to his maladaptive behaviors and psychiatric diagnoses.<br><br>The facility failed to ensure Individual #1's behavior assessment contained comprehensive information on which to base program strategies or intervention strategies.<br><br>2. Individual #2's record documented 13 year old male diagnosed with mild mental retardation, bipolar mixed with psychotic features, ADHD and mood disorder, NOS. His 5/10 IPP and 4/10 behavior assessment stated the following:<br><br>a. Individual #2's "Functional Behavioral Assessment" stated he experienced "mental illnesses and anger issues." The assessment further stated Individual #2 had a history of experiencing audio and visual hallucinations. The assessment also stated he engaged in physical assault, verbal assault, teasing/provoking others, property destruction, tantrums, and running from staff.<br><br>The "Affective Development" section of Individual #2's IPP, included diagnoses of ADHD, ODD, | W 214 | | |

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| W 214 | Continued From page 35<br>PTSD, bipolar with psychotic features, mood disorder, NOS and visual and audio command hallucinations and stated when he became angry or upset he would "often" re-enact past experiences of verbal and physical abuse. Additionally, the IPP included a "Service Object #2" which stated he "displays mal-adaptive behaviors associated with his mental illness that he requires weekly counseling to manage and reduce."<br><br>His specific diagnoses of ADHD, ODD, PTSD, bipolar with psychotic features, and mood disorder, NOS and the re-enactment of verbal and physical abuse were not identified in his behavioral assessment. Additionally, there was no information related to the relationship of his "mental illnesses" and the maladaptive behaviors Individual #2 displayed.<br><br>During an interview on 2/11/11 from 2:50 - 4:35 p.m., the Administrator stated information related to Individual #2's psychiatric diagnoses had not been used when completing the behavior assessment.<br><br>The facility failed to ensure the behavioral assessment included information as to how Individual #2's diagnoses contributed to eliciting and sustaining his maladaptive behaviors.<br><br>b. Individual #2's IPP stated he received Depakote (an anticonvulsant drug) 500 mg twice a day for physical and verbal aggression, Eskalin (an antipsychotic drug) 450 mg twice a day for manic episodes of physical aggression related to bipolar disorder and ODD and Abilify (an antipsychotic drug) 15 mg each morning. His "Functional Behavioral Assessment" did not | W 214 | | |

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| W 214 | Continued From page 36<br>include information related to the medications he was receiving for his aggression, manic episodes or his ODD.<br><br>During an interview on 2/11/11 from 2:50 - 4:35 p.m., the Administrator stated Individual #2's psychiatric medication information had not been used when completing the behavior assessment.<br><br>The facility failed to ensure the behavioral assessment included information related to Individual #2's psychiatric medications and their impact on his maladaptive behaviors.<br><br>c. Individual #2's behavioral assessment stated he engaged in verbal assault, defined as threatening staff with harm and yelling and cursing at staff. The assessment stated he used the behavior to "avoid undesirable tasks or to avoid particular situations." However, the "problem behavior 2" section of his IPP stated he would engage in verbal assault when he did not get what he wanted, when he was attention seeking and when he was seeking permission to go on an outing he had not earned. The function of Individual #2's behavior was not consistently documented in his record.<br><br>Additionally, a Level of Care Risk Assessment, dated 4/14/10, stated in the "Verbal or Physical threatening behavior" section, that Individual #2 "enjoys upsetting others and trying to get others into trouble." Information related to the enjoyment Individual #2 experienced could not be found in his behavioral assessment.<br><br>The facility failed to ensure the function of Individual #2's maladaptive behaviors were consistently documented. | W 214 | | |

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| W 214 | Continued From page 37<br><br>d. Individual #2's behavioral assessment stated he engaged in destruction of property, defined as destroying his personal items, typically his toys or property of the facility while in a fit of anger. The assessment stated destruction of property was "another way in which [Individual #2] seeks to get attention of staff." However, the "problem behavior 4" section of his IPP stated he destroyed property when he was upset with staff, family, or another resident. The function of Individual #2's behavior was not consistently documented in his record.<br><br>The facility failed to ensure the function of Individual #2's maladaptive behaviors were consistently documented.<br><br>e. A Level of Care Risk Assessment, dated 4/14/10, stated in the "Running or Wandering Away" section that Individual #2 would run from his staff in order to gain more attention, or because he was angry for not getting what he wanted at that exact time.<br><br>The "Challenging Behaviors" section of Individual #2's behavioral assessment stated he engaged in "Running from Staff." However, no additional information regarding the behavior was included in the assessment.<br><br>The facility failed to ensure the behavioral assessment included comprehensive information related to all of Individual #2's identified maladaptive behaviors.<br><br>f. Individual #2's 4/14/10 Level of Care Risk Assessment stated he engaged in threats of self harm and actual self harm including threats to | W 214 | | |

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| W 214 | Continued From page 38<br>commit suicide, suicide attempts, head banging, and self mutilation. However, no information regarding the behaviors was included in Individual #2's Functional Behavioral Assessment.<br><br>The facility failed to ensure the behavioral assessment included comprehensive information related to all of Individual #2's identified maladaptive behaviors.<br><br>g. Individual #2's 4/14/10 Level of Care Risk Assessment stated he had very poor social boundaries and was often in the personal space of others. It stated he engaged in "Socially Inappropriate Sexual Behavior" including stating he was going to hurt and rape people. The Level of Care Risk Assessment stated he required close supervision to prevent touching or hurting others sexually. However, no information regarding the behaviors was included in Individual #2's Functional Behavioral Assessment.<br><br>The facility failed to ensure the behavioral assessment included comprehensive information related to all of Individual #2's identified maladaptive behaviors.<br><br>h. Individual #2's Behavioral Tally Data Sheets for 12/10 and 1/11 documented maladaptive behaviors which included the following:<br><br>- physical intimidation<br>- task avoidance<br>- inappropriate sexual behavior<br><br>However, Individual #2's Functional Behavioral Assessment did not include information on any of the above listed behaviors. | W 214 | | |

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| W 214 | Continued From page 39<br>During an interview on 2/11/11 from 2:50 - 4:35 p.m., the Administrator stated Individual #2's behavioral assessment needed to be revised to capture all pertinent information related to his maladaptive behaviors.<br><br>The facility failed to ensure Individual #2's behavior assessment contained comprehensive information on which to base program decisions.<br><br>3. Individual #3's record documented a 15 year old male diagnosed with mild mental retardation, obsessive compulsive disorder, and schizo-affective disorder. His 4/10 IPP and behavior assessment stated the following:<br><br>a. Individual #3's IPP stated he received Abilify (an antipsychotic drug) 30 mg every evening, for schizo-affective disorder and ADHD with physical aggression and Thorazine (an antipsychotic drug) 100 mg three times daily for agitation associated with ADHD and physical aggression and Trazodone (an antidepressant drug) 150 mg every evening for insomnia. His "Functional Behavior Assessment" included the diagnoses of schizo-affective disorder and ADHD but did not include information regarding the relationship of the diagnoses and the maladaptive behaviors. Information related to Individual #3's insomnia was not included on the assessment.<br><br>During an interview on 2/11/11 from 2:50 - 4:35 p.m., the Administrator stated information related to Individual #3's psychiatric diagnoses had not been used in completion of the behavior assessment.<br><br>The facility failed to ensure the behavioral assessment included information as to how | W 214 | | |

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| W 214 | Continued From page 40<br>Individual #3's diagnoses contributed to eliciting and sustaining his maladaptive behaviors.<br><br>b. Individual #3's IPP stated stated he received Thorazine 100 mg three times daily for agitation associated with ADHD and physical aggression. Individual #3's IPP and his "Functional Behavioral Assessment" defined physical aggression as hitting and kicking others. However, the definition of agitation was not present on the IPP or the behavior assessment.<br><br>The facility failed to ensure Individual #3's agitation was sufficiently assessed.<br><br>c. Individual #3's record included a "Functional Behavioral Assessment" dated 4/10, which stated he engage in the following challenging behaviors:<br>- refusals (defined as refusing to complete tasks either verbally or by running out of the home)<br>- running away (defined as running out of the home without a staff or permission from the staff)<br><br>However, his IPP defined refusals as verbally stating he would not complete a task and running away was not defined. The IPP stated Individual #3 would run from the home 3 - 4 times per month when he became upset or mad at the staff and/or residents. Information related to Individual #3 running away when refusing a task was not included in the IPP.<br><br>When asked, the QMRP, AQMRP, and Administrator all stated, during an interview on 2/11/11 from 2:50 - 4:35 p.m., Individual #3's assessment needed to be updated as Individual #3 no longer engaged in running away.<br><br>The facility failed to ensure Individual #3's | W 214 | | |

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| W 214 | Continued From page 41<br>assessment was updated to refect his current status.<br><br>d. Individual #3's IPP stated stated he received Trazodone 150 mg every evening for insomnia. Individual #3's IPP and his "Functional Behavioral Assessment" defined difficulty falling asleep as restlessness at bedtime. The assessment stated he would turn his television down and stay awake in his room until late at night if staff did not repeatedly prompt him to go to sleep. The assessment further stated restlessness was a side effect of Individual #3's medication. However, information related to Individual #3's insomnia was not included in the assessment.<br><br>The facility failed to ensure Individual #3's restlessness was adequately assessed.<br><br>e. Individual #3's Behavioral Tally Data Sheets for 12/10 and 1/11 documented maladaptive behaviors which included the following:<br><br>- physical intimidation<br>- verbal aggression<br>- emotional outbursts<br>- task avoidance<br>- property destruction<br>- inappropriate sexual behavior<br><br>However, Individual #3's Functional Behavioral Assessment did not include information on any of the above listed behaviors.<br><br>When asked, the QMRP, AQMRP, and Administrator all stated, during an interview on 2/11/11 from 2:50 - 4:35 p.m., Individual #3's assessment needed to be updated. | W 214 | | |

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| W 214 | Continued From page 42<br>The facility failed to ensure Individual #3's behavior assessment contained comprehensive information.<br><br>4. Individual #4's record documented a 17 year old male diagnosed with mild mental retardation, ODD, mood disorder NOS, bipolar disorder with psychosis, and PTSD. His 5/10 IPP and "Functional Behavior Assessment" stated the following:<br><br>a. Individual #4's IPP stated he received Carbatrol SR (an anticonvulsant drug) 500 mg each morning and Carbatrol 400 mg each evening for control of physical aggression associated with bipolar disorder with psychosis, Clonidine (an antihypertensive drug) 0.1 mg each morning and Clonidine 0.2 mg each evening for agitation and hyperactivity associated with ADHD, Risperidone (an antipsychotic drug) 2 mg each morning and evening and Risperidone 0.5 mg each afternoon for physical and verbal aggression associated with Asperger's Syndrome and ODD and Chlorpromazine (an antipsychotic drug) 50 mg for insomnia. His "Functional Behavior Assessment" did not include any information regarding the relationship of the diagnoses and the maladaptive behaviors.<br><br>During an interview on 2/11/11 from 2:50 - 4:35 p.m., the Administrator stated information related to Individual #4's psychiatric diagnoses had not been used when completing the behavior assessment.<br><br>The facility failed to ensure the behavioral assessment included information as to how Individual #4's diagnoses contributed to eliciting and sustaining his maladaptive behaviors. | W 214 | | |

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| W 214 | Continued From page 43<br><br>b. Individual #4's IPP stated he received Clonidine 0.1 mg each morning and Clonidine 0.2 mg each evening for agitation and hyperactivity associated with ADHD. However, the definition of agitation and hyperactivity was not present on the IPP or the behavior assessment.<br><br>The facility failed to ensure Individual #4's agitation and hyperactivity were sufficiently assessed.<br><br>c. Individual #4's IPP stated he received Chlorpromazine 50 mg for insomnia. His "Functional Behavior Assessment" did not include any information regarding the relationship of the insomnia diagnosis and his restlessness. His "Functional Behavioral Assessment" stated the behavior was used to gain control over his environment and exert his independence. However, information related to Individual #4's insomnia was not included in the assessment.<br><br>When asked, the Administrator stated during an interview on 2/11/11 from 10:30 a.m. - 12:25 p.m., Individual #4 was no longer taking Chlorpromazine for sleep, but sleep should be tracked.<br><br>The facility failed to ensure Individual #4's insomnia was sufficiently assessed.<br><br>d. His record included a Behavioral Tally Data Sheet for 12/10 and 1/11, which documented he engaged in emotional outbursts (not defined). However, Individual #4's Functional Behavior Assessment, dated 5/10, did not identify or assess emotional outbursts. | W 214 | | |

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| W 214 | Continued From page 44<br>When asked, the QMRP, AQMRP, and Administrator all stated, during an interview on 2/11/11 from 2:50 - 4:35 p.m., Individual #4 had emotional outbursts and the assessment needed to be updated.<br><br>The facility failed to ensure the behavioral assessment included comprehensive information related to all Individual #4's identified maladaptive behaviors.<br><br>e. Individual #4's Functional Behavior Assessment, dated 5/10, documented he engaged in refusing to attend school (defined as refusing to attend school, get on the bus, or get dressed on school days).<br><br>When asked, the QMRP, AQMRP, and Administrator all stated, during an interview on 2/11/11 from 2:50 - 4:35 p.m., Individual #4 no longer refused to attend school.<br><br>The facility failed to ensure Individual #4's behavioral assessment was revised to reflect accurate information.<br><br>f. Individual #4's Functional Behavior Assessment, dated 5/10, documented he engaged in socially inappropriate behaviors (defined as running to neighbors' houses and knocking on the door or ringing the doorbell multiple times, walking through neighbors' personal property, and stepping on their landscaping). However, his PBSP, dated 5/10, did not include an objective related to socially offensive behavior.<br><br>When asked, the QMRP, AQMRP, and Administrator all stated, during an interview on | W 214 | | |

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| W 214 | Continued From page 45<br>2/11/11 from 2:50 - 4:30 p.m., Individual #4's assessment needed to be updated to reflect that he no longer engaged in socially offensive behavior.<br><br>The facility failed to ensure Individual #4's behavior assessment contained accurate and comprehensive information. | W 214 | | |
| W 227 | 483.440(c)(4) INDIVIDUAL PROGRAM PLAN<br><br>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interviews, it was determined the facility failed to ensure individuals' IPPs included objectives to meet their needs for 4 of 4 individuals (Individuals #1 - #4) whose behavioral plans were reviewed. This resulted in a lack of program plans designed to address the needs of individuals in areas most likely to impact their lives. The findings include:<br><br>1. Individual #2's 5/10 IPP stated he was a 13 year old male whose diagnoses included bipolar mixed with psychotic features, ADHD, mild mental retardation, and mood disorder.<br><br>a. Individual #2's record included Behavioral Tally Data sheets, dated 12/10 and 1/11, which documented he engaged in physical intimidation, emotional outbursts, and task avoidance, all undefined.<br><br>However, Individual #2's IPP did not include | W 227 | | |

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| W 227 | Continued From page 46<br>objectives for physical intimidation, emotional outbursts, or task avoidance.<br><br>b. Individual #2's Physician's Order Form, dated 1/11/11, stated he received Concerta (a central nervous system drug) 54 mg daily. A Telephone/Verbal Consent Form, dated 1/24/11, stated Concerta was for making "whoop" noises and verbal assault.<br><br>During an interview on 2/11/11 from 2:50 - 4:35 p.m., the Administrator stated the drug was actually for ADHD exhibited by other behaviors in addition to making "whoop" noises.<br><br>However, Individual #2's IPP did not include an objective related to "whoop" noises or ADHD.<br><br>c. Individual #2's 2/11 MAR stated he received trazodone (an antidepressant drug) 50 - 150 mg PRN for insomnia.<br><br>However, Individual #2's IPP did not include an objective related to sleep.<br><br>d. Individual #2's 4/14/10 Level of Care Risk Assessment stated he engaged in threats of self harm and actual self harm including threats to commit suicide, suicide attempts, head banging, and self mutilation. Additionally, Individual #2's record documented he had made threats of suicide at the facility on 7/1/10 and 10/3/10, and twice at school in 12/10 with the most significant being 12/10/10 where he attempted to wrap clothing items around his neck and pull them tight.<br><br>However, Individual #2's IPP did not include an objective related to suicide or self harm. | W 227 | | |

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| W 227 | Continued From page 47<br><br>e. A Level of Care Risk Assessment, dated 4/14/10, stated in the "Running or Wandering Away" section that Individual #2 would run from his staff in order to gain more attention, or because he was angry for not getting what he wanted at that exact time. The "Challenging Behaviors" section of Individual #2's behavioral assessment stated he engaged in "Running from Staff."<br><br>However, Individual #2's IPP did not include an objective related to running or wandering away.<br><br>During an interview on 2/11/11 from 2:50 - 4:30 p.m., the QMRP, AQMRP and Administrator all stated objectives for all Individual #2's identified behaviors had not been developed and the IPP needed to be revised.<br><br>2. Individual #1's IPP, undated, stated he was a 12 year old male whose diagnoses included ADHD, PTSD, mild mental retardation, and impulse control disorder. He was admitted to the facility on 9/21/10.<br><br>Individual #1's record included Behavioral Tally Data sheets, dated 12/10 and 1/11, which documented he engaged in "Inappropriate Sexual" behavior, undefined.<br><br>However, Individual #1's IPP did not include objectives related to inappropriate sexual behavior.<br><br>During an interview on 2/11/11 from 2:50 - 4:30 p.m., the QMRP and Administrator stated an objective for inappropriate sexual behavior had not been developed and the IPP needed to be | W 227 | | |

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| W 227 | Continued From page 48<br>revised.<br><br>3. Individual #3's record documented a 15 year old male diagnosed with mild mental retardation, obsessive compulsive disorder, and schizo-affective disorder.<br><br>a, Individual #3's Behavioral Tally Data Sheets for 12/10 and 1/11 documented maladaptive behaviors which included the following:<br><br>- physical intimidation<br>- verbal aggression<br>- emotional outbursts<br>- task avoidance<br>- property destruction<br>- inappropriate sexual behavior<br><br>However, Individual #3's IPP did not include objectives for any of the above listed behaviors.<br><br>b. Individual #3's IPP stated stated he received Thorazine 100 mg three times daily for agitation associated with ADHD and physical aggression.<br><br>However, Individual #3's IPP did not include an objective for agitation.<br><br>When asked, the QMRP, AQMRP, and Administrator all stated, during an interview on 2/11/11 from 2:50 - 4:35 p.m., Individual #3's IPP needed to be updated to include objectives related to his displayed behaviors.<br><br>The facility failed to ensure objectives were developed to meet Individual #3's behavioral needs.<br><br>4. Individual #4's record documented a 17 year | W 227 | | |

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| W 227 | Continued From page 49<br>old male diagnosed with mild mental retardation, oppositional defiant disorder, mood disorder NOS, bipolar disorder with psychosis, and PTSD.<br><br>a. His record included Behavioral Tally Data Sheets for 12/10 and 1/11, which documented he engaged in emotional outbursts (not defined).<br><br>However, Individual #4's IPP, dated 5/10, did not include objectives related to emotional outbursts.<br><br>b. Individual #4's IPP stated he received Clonidine 0.1 mg each morning and Clonidine 0.2 mg each evening for agitation and hyperactivity associated with ADHD.<br><br>However, Individual #4's IPP did not include objectives for agitation or hyperactivity.<br><br>When asked, the QMRP, AQMRP, and Administrator all stated, during an interview on 2/11/11 from 2:50 - 4:35 p.m., Individual #4's IPP needed to be updated to include an objective emotional outbursts.<br><br>The facility failed to ensure objectives were developed to meet Individual #4's behavioral needs. | W 227 | | |
| W 239 | 483.440(c)(5)(vi) INDIVIDUAL PROGRAM PLAN<br><br>Each written training program designed to implement the objectives in the individual program plan must specify provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate. | W 239 | | |

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| W 239 | Continued From page 50<br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview, it was determined the facility failed to ensure appropriate replacement behaviors were identified and incorporated into the behavior intervention programs for 4 of 4 individuals (Individuals #1 - #4) whose behavior intervention plans were reviewed. This resulted in individuals not receiving training to replace maladaptive behaviors. The findings include:<br><br>1. Individual #1's IPP, undated, stated he was a 12 year old male whose diagnoses included ADHD, PTSD, mild mental retardation, and impulse control disorder. He was admitted to the facility on 9/21/10.<br><br>a. Individual #1's "Functional Behavioral Assessment," dated 11/10, documented he engaged in physical intimidation (defined as making threatening gestures to others, getting into the face of staff or peers, and using his size to intimidate others around him) for "task avoidance." Individual #1's PBSP, dated 5/10, included the following replacement behavior for physical intimidation:<br><br>"Given direct verbal prompts, [Individual #1] will comply with staff requests..."<br><br>The objective did not include training to teach Individual #3 appropriate alternatives to physical intimidation.<br><br>b. Individual #1's "Functional Behavioral Assessment," dated 11/10, documented he engaged in property damage (defined as breaking personal and facility property, including breaking windows and punching walls) to "gain control over | W 239 | | |

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| W 239 | Continued From page 51<br>his environment and exert his independence." Individual #1's PBSP, dated 5/10, included the following replacement behavior for property damage:<br><br>"Given a direct verbal prompt or less, [Individual #1] will increase his instances of naming the emotion he is feeling to staff..."<br><br>It was not clear how "naming the emotion" he was feeling was related to gaining control of his environment and exerting his independence.<br><br>During an interview on 2/11/11 from 2:50 - 4:35 p.m., the QMRP, AQMRP and Administrator all stated replacement behaviors needed to be revised and for all individuals residing at the facility.<br><br>2. Individual #2's 5/10 IPP stated he was a 13 year old male whose diagnoses included bipolar mixed with psychotic features, ADHD, mild mental retardation, and mood disorder.<br><br>a. Individual #2's "Functional Behavioral Assessment," dated 4/10, documented he engaged in property destruction (defined as destroying his personal items or property of the facility while in a fit of anger) was "to get the attention of staff." Individual #2's PBSP, dated 5/10, included the following replacement behavior for property destruction:<br><br>"Given a direct verbal prompt or less, [Individual #2] will increase his instances of talking about his anger to staff..."<br><br>It was not clear how talking about his anger was related to appropriately gaining staff's attention. | W 239 | | |

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| W 239 | Continued From page 52<br><br>b. Individual #2's PBSP, dated 5/10, documented he engaged in sexually inappropriate behaviors (defined as poking female staff in the breast area and making inappropriate sexual comments or gestures). His 4/10 Functional Behavioral Assessment did not address sexually inappropriate behaviors. Individual #2's PBSP included the following replacement behavior for sexually inappropriate behaviors:<br><br>"Given a direct verbal prompt or less, [Individual #2] will increase his communication skills to get the things that he wants..."<br><br>It was not clear how increasing expression of wants was related to his sexually inappropriate behaviors, given the lack of functional assessment.<br><br>During an interview on 2/11/11 from 2:50 - 4:35 p.m., the QMRP, AQMRP and Administrator all stated replacement behaviors needed to be revised and for all individuals residing at the facility.<br><br>3. Individual #3's record documented a 15 year old male diagnosed with mild mental retardation, obsessive compulsive disorder, and schizo-affective disorder.<br><br>a. Individual #3's Functional Behavioral Assessment, dated 4/10, documented he engaged in physical aggression (defined as hitting and kicking staff and other residents) for "retaliation and to make the verbal abuse, or perceived verbal abuse, stop." Individual #3's PBSP, dated 5/10, included the following replacement behavior for physical aggression: | W 239 | | |

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| W 239 | Continued From page 53<br><br>"[Individual #3] will have 3 or more instances per month of discussion [sic] his anger with staff when he becomes angry or upset with those around him."<br><br>It was not clear how discussing his anger was related to retaliation and stopping verbal abuse.<br><br>b. Individual #3's Functional Behavioral Assessment, dated 4/10, documented he engaged in refusal (defined as verbally refusing to complete a task) to avoid tasks he did not enjoy. Individual #3's PBSP, dated 5/10, included the following replacement behavior for refusal:<br><br>"When given a verbal prompt or less, [Individual #3] will complete his required tasks without refusals 5 out of 7 trials per month."<br><br>The objective did not include training to teach Individual #3 appropriate alternatives to refusing tasks.<br><br>c. Individual #3's Functional Behavioral Assessment, dated 4/10, documented he engaged in difficulty falling asleep (defined as "acting restless at bedtime and having difficulty falling asleep"). Individual #3's PBSP, dated 5/10, included the following replacement behavior for falling asleep:<br><br>"When given direct verbal prompts, [Individual #3] will stay in his bed when prompted to go to sleep at the appropriate hours in 80% of trials."<br><br>The objective did not include training to teach Individual #3 appropriate sleep habits. | W 239 | | |

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| W 239 | Continued From page 54<br>When asked, the QMRP, AQMRP, and Administrator all stated, during an interview on 2/11/11 from 2:50 - 4:35 p.m., Individual #3's replacement behaviors needed to be revised.<br><br>The facility failed to ensure appropriate replacement behaviors were developed for Individual #3.<br><br>4. Individual #4's record documented a 17 year old male diagnosed with mild mental retardation, ODD, mood disorder NOS, bipolar disorder with psychosis, and PTSD.<br><br>a. Individual #4's Functional Behavior Assessment, dated 5/10, documented he engaged in physical intimidation (defined as "making threatening gestures, getting into the face of staff or peers, and using physical stature to intimidate others") to avoid tasks.<br><br>Individual #4's PBSP, dated 5/10, included the following replacement behavior tied to physical intimidation:<br><br>"Given direct verbal prompts, [Individual #4] will comply with staff requests in 50% of trials per month."<br><br>The objective did not include training to teach Individual #4 options or appropriate ways to refuse requests.<br><br>b. Individual #4's Functional Behavior Assessment, dated 5/10, documented he engaged in restlessness/difficulty falling asleep (defined as "becoming more awake and restless as it gets closer to night time") to gain control over the environment and exert independence. | W 239 | | |

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| W 239 | Continued From page 55<br><br>Individual #4's PBSP, dated 5/10, included the following replacement behavior tied to restlessness/difficulty falling asleep:<br><br>"Given direct verbal prompts, [Individual #4] will comply with staff prompts to go to bed."<br><br>However, it was not clear what training was being provided to Individual #4 to teach him appropriate sleep habits.<br><br>When asked, the QMRP, AQMRP, and Administrator all stated, during an interview on 2/11/11 from 2:50 - 4:35 p.m., Individual #4's replacement behaviors needed to be revised.<br><br>The facility failed to ensure appropriate replacement behaviors were developed for Individual #4. | W 239 | | |
| W 252 | 483.440(e)(1) PROGRAM DOCUMENTATION<br><br>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interviews, it was determined the facility failed to ensure data was collected sufficiently to determine the efficacy of the intervention strategies for of 4 of 4 individuals (Individuals #1 - #4) whose behavior data was reviewed. That failure had the potential to impede the ability of the IDT in evaluating the effectiveness of programmatic techniques. The findings include: | W 252 | | |

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| W 252 | Continued From page 56<br><br>1. The facility used an ABC form to record individuals' maladaptive behaviors. Staff were to document "A" what happened before, "B" during, and "C" after the maladaptive behavior. The form had additional space for duration of the behavior and documentation of review by the QMRP, AQMRP, or Administrator.<br><br>ABC forms for Individuals #1 - #4 were reviewed from 9/1/10 - 1/31/11. The forms did not document sufficient information was collected regarding individuals' maladaptive behaviors to adequately assess the efficacy of the intervention strategies as follows:<br><br>a. Individual #1's IPP, undated, stated he was a 12 year old male whose diagnoses included ADHD, PTSD, mild mental retardation, and impulse control disorder. He was admitted to the facility on 9/21/10.<br><br>Individual #1's PBSP, dated 5/10, documented he engaged in task avoidance/defiance (defined as refusing to comply with staff requests or complete tasks), verbal aggression/defiance (defined as yelling, swearing, or making derogative comments to staff or peers), physical intimidation (defined as making threatening gestures to others, getting into the face of staff or peers, and using his size to intimidate others), physical aggression (defined as hitting, spitting, kicking, or biting when he is angry), tantrums (defined as throwing items around the room, crying uncontrollably, falling to the ground, and flinging arms around), and property destruction (defined as breaking his toys or the facility's property while angry). | W 252 | | |

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| W 252 | Continued From page 57<br>The data collected on Individual #1's ABC forms was not sufficient. Examples included, but were not limited to, the following:<br><br>- 1/21/11: Individual #1 "displayed difficulty complying with staff's requests" throughout the day. He was asked to brush his teeth several times but refused. The "Consequence" section stated he did not earn part of his allowance.<br><br>The ABC form did not document what other staff requests Individual #2 had difficulty complying with, if other options had been presented to Individual #2, how staff had prompted, or Individual #2's response to staff's interventions.<br><br>- 1/24/11: Individual #1 was in "the car" when he began kicking, throwing things, and hitting the window. The events continued "for about" 5 minutes, at which time he "began using profane language and yelled." The "Consequence" section documented he did not earn his allowance and "it was explained to him that what he was doing was wrong."<br><br>The ABC form did not document the progression of staff interventions (i.e., at which points during the maladaptive behavior did staff intervene and how), or Individual #1's response to staff's interventions.<br><br>- 1/26/11: Individual #1 refused to go to bed and "tried various ways to stay up." The "Consequence" section documented he did not earn allowance.<br><br>The ABC form did not document the progression of events (i.e., the "various ways" Individual #1 tried to stay up, staff's response, etc.), | W 252 | | |

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| W 252 | Continued From page 58<br>interventions used by staff, or Individual #1's response to those interventions.<br><br>- 1/27/11: When prompted to go to bed, Individual #1 spent 20 minutes attempting to get snacks. When told no, he "had small outbursts." Individual #1 was redirect to his room where the behavior lasted for the remainder of the shift (documented as 2 hours 15 minutes) at which time graveyard staff took over. During the maladaptive behavior, Individual #2 threw books and shoes at staff, broke a patched part of a wall, swore at staff, made "verbal and gesturing threats," and "tried continously [sic] to leave his room." The "Consequence" section documented "Failed Behavioral objective" #1 - #6 and failed "replacement objective" #1 - #6.<br><br>The ABC form did not document the progression of Individual #1's maladaptive behavior, what interventions staff implemented at which points during the maladaptive behaviors, or Individual #1's response to the interventions. Additionally, the ABC form did not document how staff were preventing Individual #1 from leaving his room when he "tried continuously [sic] to leave his room," and if this intervention constituted a restraint or not.<br><br>Individual #1's data did not provide sufficient information that would allow the facility to analyze the severity of the maladaptive behavior, or the effectiveness or appropriateness of the interventions.<br><br>During an interview on 2/11/11 from 2:50 - 4:35 p.m., the Administrator and QMRP both stated the data collected was not sufficient or comprehensive. | W 252 | | |

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| W 252 | Continued From page 59<br><br>b. Individual #2's 5/10 IPP stated he was a 13 year old male whose diagnoses included bipolar mixed with psychotic features, ADHD, mild mental retardation, and mood disorder.<br><br>Individual #2's PBSP, dated 5/10, documented he engaged in physical aggression towards others (defined as hitting, kicking, and/or spitting on those around him), verbal assault to staff (defined as threatening staff with harm or cursing at staff when angry), teasing/provoking other residents (defined as poking residents with his finger, taunting other residents who are in restraint, or doing things that others do not like in order to "get a reaction from the resident"), property destruction (defined as breaking his toys or the facility property), tantrums (defined as falling to the ground kicking, crying and screaming), and sexually inappropriate behaviors (poking female staff in the breast area and making inappropriate sexual comments or gestures).<br><br>The data collected on Individual #2's ABC forms was not sufficient. Examples included, but were not limited to, the following:<br><br>- 9/8/10: Individual #2 had been cleaning out the facility van when he lost interest and then locked himself in the van and honked the horn repeatedly. Charge Staff came out with the keys and Individual #2 began evading staff. The "Consequence" section stated he did not earn his allowance and he was redirected to his room until he was calm.<br><br>The ABC form did not indicate the interventions used by staff to redirect Individual #2's maladaptive behaviors. Further, the form did not | W 252 | | |

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| W 252 | Continued From page 60<br>describe what "evading" looked like (i.e., running from staff, stepping out of their way, moving from one side of the van to the other, etc.).<br><br>- 9/9/10: Individual #2 was aggravating another individual and staff redirected him to his room. Once in his room, Individual #2 verbally and physically assaulted staff.<br><br>The ABC form did not include descriptions of the behaviors (i.e., what aggravating entailed or what he specifically did to verbally and physically assault staff), interventions used, or if the interventions were effective.<br><br>- 9/10/10: Individual #2 was told he could not play a video game at the bowling alley. Individual #2 ran away three or four times, threw objects, hit, kicked, tried to open the cash register, and threw his bowling shoes into the street. The "Consequence" section stated he did not earn all of his allowance.<br><br>The ABC form did not clearly document what Individual #2 did in what order, what interventions were implemented by staff and in what order, or how Individual #2 responded to those interventions.<br><br>- 10/23/10: Individual #2 was cued to go to bed. He tried to lock himself in the therapy room, took his clothes off, and ran through the house. The "Consequence" section stated he did not earn part of his allowance.<br><br>The ABC form did not document what interventions staff implemented in response to Individual #2's maladaptive behavior. | W 252 | | |

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| W 252 | Continued From page 61<br>- 10/29/10: Individual #2 was supposed to be asleep but was yelling, screaming, and hitting the walls in his room. The form stated he repeatedly attempted to go to the living room and lay on the couch and ask for snacks. The "Consequence" section stated Individual #2 was "going to be tired for Haloween [sic] because he did not go to bed at a decent time. Must regain priveleges [sic] for tomorrow."<br><br>The ABC form did not document what interventions staff implemented in response to Individual #2's maladaptive behavior.<br><br>- 11/6/10: Individual #2 was provoking another individual. When the other individual reacted, Individual #2 "flipped her off several times." The "Consequence" section stated Individual #2 was unable to earn all of his allowance.<br><br>The ABC form did not document what "provoking" another individual meant or what interventions staff implemented in response to Individual #2's maladaptive behavior.<br><br>- 11/10/10: Individual #2 was cued to take a shower. He became verbally assaultive with staff and punched walls. The "Consequence" section stated Individual #2 did not earn all of his allowance.<br><br>The ABC form did not document the progression of the behavior, what interventions staff implemented in response to Individual #2's maladaptive behavior, or his response to those interventions.<br><br>- 11/15/10: Individual #2 walked up to a female staff, said "Bean dip" and flicked her chest and | W 252 | | |

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| W 252 | Continued From page 62<br>stomach. The "Consequence" section documented he did not earn his allowance.<br><br>The ABC form did not document what interventions staff implemented in response to Individual #2's maladaptive behavior, or his response to those interventions.<br><br>- 11/14/10: Individual #2 was "verbally harassing" other individuals, staff repeatedly asked him not to, he refused, continued to verbally harass others, and swore at staff. The "Consequence" section documented he was redirected to his bedroom and he did not earn his allowance.<br><br>The ABC form did not document what "verbally harassing" other individuals meant, did not document the progression of the maladaptive behavior and staff interventions, or Individual #2's response to the interventions.<br><br>Individual #2's data did not provide sufficient information that would allow the facility to analyze the severity of the maladaptive behavior, or the effectiveness or appropriateness of the interventions.<br><br>During an interview on 2/11/11 from 2:50 - 4:35 p.m., the Administrator and QMRP both stated the data collected was not sufficient or comprehensive.<br><br>c. Individual #4's record documented a 17 year old male diagnosed with mild mental retardation, oppositional defiant disorder, mood disorder NOS, bipolar disorder with psychosis, and PTSD.<br><br>Individual #4's PBSP, dated 5/10, documented he engaged in physical aggression (defined as | W 252 | | |

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| W 252 | Continued From page 63<br>hitting, kicking, spitting, and biting), physical intimidation (defined as making threatening gestures, getting into the face of staff or peers, and using physical stature to intimidate others), verbal aggression/intimidation (defined as yelling, swearing, and making derogative comments), task avoidance/defiance (defined as refusing to comply with staff requests or complete tasks), refusal to attend school (defined as refusing to attend school, get on the bus, or get dressed), property damage (defined as breaking personal and facility property), and restlessness/difficulty falling asleep (defined as becoming more awake and restless as it gets close to night time).<br><br>The data collected on Individual #4's ABC forms was not sufficient. Examples included, but were not limited to, the following:<br><br>- 9/1/10: Individual #4 was watching television when another individual offered him sunflower seeds. The ABC form documented Individual #4 got angry and kicked the other individual. The other individual kicked back, and Individual #4 punched him in the face. Under the section titled "Consequence" staff noted Individual #4 did not earn his allowance.<br><br>The ABC form did not document what interventions staff used as the behavior progressed or if the consequence was effective.<br><br>- 9/16/10: Individual #4 was prompted to cook dinner. He argued with staff and swore. The "Consequence" section documented Individual #4 calmed down and finished cooking dinner.<br><br>The ABC form did not document what interventions staff used to help calm him and | W 252 | | |

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| W 252 | Continued From page 64<br>redirect him to the task.<br><br>- 9/16/10: Individual #4 invaded the personal space of others throughout the day. He did not earn his allowance.<br><br>The ABC form did not document what "invading personal space" looked like, what interventions staff used to redirect the behavior, or if the consequence was effective at changing the behavior.<br><br>- 10/1/10: Individual #4 was playing football with other individuals and staff. He got into arguments with 2 individuals which led to yelling, swearing, and threats. The "Consequence" section documented Individual #4 "went inside and played video games instead of football, which calmed him down."<br><br>The ABC form did not document what interventions staff used to redirect Individual #4's behavior.<br><br>- 11/10/10: Individual #4 invaded the personal space of other individual's and staff.<br><br>The ABC form did not document what "invading personal space" looked like, what interventions staff used to redirect the behavior, or if the consequence was effective.<br><br>- 11/22/10: Individual #4 verbally threatened another individual. He did not earn a star.<br><br>The ABC form did not document what interventions staff used to redirect the behavior, if they were effective or if the consequence was effective. | W 252 | | |

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| W 252 | Continued From page 65<br><br>- 12/4/10: Individual #4 was prompted to shower. He refused.<br><br>The ABC form did not document what interventions staff used and whether or not they were effective.<br><br>- 12/7/10: Individual #4 refused to do his chores. He did not earn allowance.<br><br>The ABC form did not document what interventions staff used to redirect his behavior or if the consequence was effective.<br><br>- 1/2/11: Individual #4 got upset, tried to refuse medication, and slammed the door.<br><br>The ABC form did not document what interventions staff used to redirect the behavior, nor whether or not they were effective.<br><br>When asked, the QMRP stated, during an interview on 2/11/11 from 2:50 - 4:35 p.m., the ABC forms did not contain sufficient information.<br><br>The facility failed to ensure data collected for Individual #4's maladaptive behaviors provided sufficient information to adequately assess the efficacy of the intervention strategies.<br><br>d. Individual #3's record documented a 15 year old male diagnosed with mild mental retardation, obsessive compulsive disorder, and schizo-affective disorder.<br><br>Individual #3's PBSP, dated 5/10, documented he engaged in physical aggression (defined as hitting and kicking others), refusal (defined as verbally | W 252 | | |

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| W 252 | Continued From page 66<br>refusing to complete a task), running away (undefined), difficulty falling asleep (defined as restlessness at bedtime and having difficulty falling asleep).<br><br>The data collected on Individual #3's ABC forms was not sufficient. Examples included, but were not limited to, the following:<br><br>- 9/14/10: Individual #3 "was cussing at staff and refused to put his seatbelt on in the van, very verbally aggressive. Once he put his Seat Belt [sic] on he remained silent all the way home. Once home he called his mom, after phone call he started crying and throwing his Items [sic] all around his room and punching and kicking his walls. he wa [sic] very upset." Under the section titled "Consequence" staff noted he did not earn his allowance.<br><br>The ABC form did not document staff interventions as the behavior progressed or if the consequence was effective.<br><br>- 10/29/10: Individual #3 refused to take a shower and did not earn allowance.<br><br>The ABC form did not document what interventions staff used to redirect the behavior and if the consequence was effective.<br><br>- 11/1/10: Individual #3 was asked to get up and take his medication. He attempted to watch television and was told he had not earned television. Individual #3 got upset, started pushing chairs, throwing things at staff, and cussing at staff. The "Consequence" section documented Individual #3 did not earn allowance and was restrained. | W 252 | | |

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| W 252 | Continued From page 67<br><br>The ABC form did not document the sequence of events leading up to the restraint and what interventions staff used prior to the restraint. Further there was no indication if the consequences were effective.<br><br>- 1/10/11: Individual #3 refused to go to school and he did not earn allowance or a morning star.<br><br>The ABC form did not document what interventions staff used to redirect his behavior or if the consequence was effective.<br><br>When asked, the QMRP stated, during an interview on 2/11/11 from 2:50 - 4:35 p.m., the ABC forms did not contain sufficient information.<br><br>The facility failed to ensure data collected for Individuals #1 - #4's maladaptive behaviors provided sufficient information to adequately assess the efficacy of the intervention strategies. | W 252 | | |
| W 262 | 483.440(f)(3)(i) PROGRAM MONITORING & CHANGE<br><br>The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interviews, it was determined the facility failed to ensure restrictive interventions were implemented only with the approval of the human rights committee for 4 of 4 individuals (Individuals #1 - #4) whose restrictive interventions were reviewed. This | W 262 | | |

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| W 262 | Continued From page 68<br>resulted in a lack of protection of individuals' rights through prior approvals of restrictive interventions. The findings include:<br><br>1. Individual #1's IPP, undated, stated he was a 12 year old male whose diagnoses included ADHD, PTSD, mild mental retardation, and impulse control disorder. He was admitted to the facility on 9/21/10.<br><br>Individual #1's 1/11 MAR stated he received Strattera (a central nervous system drug) 40 mg daily for ADHD, topiramate (an anticonvulsant drug) 25 mg daily for PTSD, divalproex sodium (an anticonvulsant drug) 500 mg daily for mood control, and guanfacine HCL (an antihypertensive drug) 2 mg daily for ADHD. His record documented he was admitted to the facility with these drugs prescribed.<br><br>However, Individual #1's record did not contain HRC approval for the drugs.<br><br>During an interview on 2/11/11 from 10:30 a.m. - 12:25 p.m., the Administrator stated the facility had mailed written informed consents to Individual #1's guardian, but the consents had not been returned and forwarded to the HRC for review. The Administrator stated HRC approval for Individual #1's behavior modifying drugs had not been obtained.<br><br>The facility failed to ensure Individual #1's behavior modifying drugs were implemented only with approval of the HRC.<br><br>2. Individual #2's 5/10 IPP stated he was a 13 year old male whose diagnoses included bipolar mixed with psychotic features, ADHD, mild | W 262 | | |

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| W 262 | Continued From page 69<br>mental retardation, and mood disorder.<br><br>Individual #2's 2/11 MAR stated he received Abilify (an antipsychotic drug) 15 mg daily for aggression/agitation, Concerta (a central nervous system drug) 54 mg daily for ADHD, divalproex sodium (an anticonvulsant drug) 1500 mg daily for aggression, lithium carbonate (an antipsychotic drug) 1200 mg daily for aggression, and trazodone (an antidepressive drug) 50 - 150 mg nightly for insomnia.<br><br>Individual #2's record contained two HRC Approval Request Forms, one dated 2/1/11 for Concerta and one dated 12/22/10 for divalproex sodium. However, the forms did not include documented approval from the HRC.<br><br>Additionally, Individual #2's record did not contain HRC approval for Abilify, lithium carbonate, or trazodone.<br><br>During an interview on 2/11/11 from 10:30 a.m. - 12:25 p.m., the Administrator stated a signature sheet should have been attached to the HRC Approval Request Forms indicating the HRC had reviewed and approved the drugs. The Administrator stated it did not appear that HRC approval had been obtained for the drugs.<br><br>The facility failed to ensure Individual #2's behavior modifying drugs were implemented only with approval of the HRC.<br><br>3. Individual #3's record documented a 15 year old male diagnosed with mild mental retardation, obsessive compulsive disorder, and schizo-affective disorder. His record included a physician's order, dated 1/11/11, which | W 262 | | |

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| W 262 | Continued From page 70<br>documented he received 150 mg of trazodone (an antidepressant drug) nightly. The order further stated the start date of trazodone was 2/16/10.<br><br>Individual #3's record contained an HRC Approval Request Form, dated 3/10/10, for trazodone. However, his record did not include documentation the HRC had approved the use of trazodone.<br><br>When asked, the Administrator stated during an interview on 2/11/11 from 10:30 a.m. - 12:25 p.m., HRC approval was not documented due to an oversight.<br><br>The facility failed to ensure HRC approval was obtained prior to the use of trazodone for Individual #3.<br><br>4. Individual #4's record documented a 17 year old male diagnosed with mild mental retardation, oppositional defiant disorder, mood disorder NOS, bipolar disorder with psychosis, and PTSD. His record included a physician's order, dated 6/29/10, which documented he received Risperdal (an antipsychotic drug) 2 mg two times daily and 0.5 mg once daily.<br><br>Individual #4's record included a verbal HRC approval, dated 1/10/11. There was no documentation the HRC had approved the use of the drug between 6/29/10 and 1/10/11.<br><br>When asked, the Administrator stated during an interview on 2/11/11 from 10:30 a.m. - 12:25 p.m., HRC approval was not documented for the time period in question due to an oversight. | W 262 | | |

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| W 262 | Continued From page 71<br>The facility failed to ensure HRC approval was obtained prior to the use of Risperdal for Individual #4. | W 262 | | |
| W 263 | 483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE<br><br>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interviews, it was determined the facility failed to ensure restrictive interventions were implemented only with the written informed consent of the parent/guardian for 4 of 4 individuals (Individuals #1 - #4) whose restrictive interventions were reviewed. This resulted in a lack of protection of individuals' rights through prior consent for restrictive interventions. The findings include:<br><br>1. Individual #1's IPP, undated, stated he was a 12 year old male whose diagnoses included ADHD, PTSD, mild mental retardation, and impulse control disorder. He was admitted to the facility on 9/21/10.<br><br>The facility utilized a Telephone/Verbal Consent Form to obtain initial consent for restrictive interventions. The form stated telephone or verbal consent for restrictive interventions expired 30 days after the consent was obtained and must be followed by written informed consent from the guardian.<br><br>Individual #1's 1/11 MAR stated he received Strattera (a central nervous system drug) 40 mg | W 263 | | |

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| W 263 | Continued From page 72<br>daily for ADHD, topiramate (an anticonvulsant drug) 25 mg daily for PTSD, divalproex sodium (an anticonvulsant drug) 500 mg daily for mood control, and guanfacine HCL (an antihypertensive drug) 2 mg daily for ADHD. His record documented he was admitted to the facility with the drugs prescribed.<br><br>a. Individual #1's record contained Telephone/Verbal Consent Forms for each of the drugs, all dated 9/29/10. The Forms documented Individual #1's father/guardian had provided telephone consent to the facility's LPN. The Telephone/Verbal Consent Forms expired 10/29/10 (30 days from the date consent was obtained).<br><br>However, Individual #1's record did not include documentation that written informed consent had been obtained for the drugs.<br><br>b. Individual #1's record included a second set of Telephone/Verbal Consent Forms for each of the drugs, all dated 11/18/10. The Forms documented Individual #1's father/guardian had provided telephone consent to the facility's AQMRP. The Telephone Verbal Consent Forms expired 12/18/10 (30 days from the date consent was obtained).<br><br>However, Individual #1's record did not include documentation that written informed consent had been obtained for the drugs.<br><br>During an interview on 2/11/11 from 10:30 a.m. - 12:25 p.m., the Administrator stated the facility had mailed written informed consents to Individual #1's guardian, but the consents had not been returned. The Administrator stated this | W 263 | | |

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| W 263 | Continued From page 73<br>information was not documented, and she was not sure what to do if a guardian did not return the consents prior to the expiration of the verbal consent.<br><br>The facility failed to ensure written informed consent was obtained from the guardian prior to the expiration of the verbal consent for Individual #1's behavior modifying drugs.<br><br>2. Individual #2's 5/10 IPP stated he was a 13 year old male whose diagnoses included bipolar mixed with psychotic features, ADHD, mild mental retardation, and mood disorder.<br><br>Individual #2's 2/11 MAR stated he received Abilify (an antipsychotic drug) 15 mg daily for aggression/agitation, Concerta (a central nervous system drug) 54 mg daily for ADHD, divalproex sodium (an anticonvulsant drug) 1500 mg daily for aggression, lithium carbonate (an antipsychotic drug) 1200 mg daily for aggression, and trazodone (an antidepressive drug) 50 - 150 mg nightly for insomnia.<br><br>Individual #2's record contained two HRC Approval Request Forms, one dated 2/1/11 for Concerta and one dated 12/22/10 for divalproex sodium. Both HRC Approval Request Forms were signed by Individual #2's guardian.<br><br>However, Individual #2's record did not contain documentation of written informed guardian consent for Abilify, lithium carbonate, or trazodone.<br><br>During an interview on 2/11/11 from 10:30 a.m. - 12:25 p.m., the Administrator stated the HRC Approval Request Form, once signed by the | W 263 | | |

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| W 263 | Continued From page 74<br>guardian, was the facility's written informed consent document. The Administrator stated the facility's LPN was responsible for obtaining consents, and stated it appeared consent had not been obtained.<br><br>During a telephone interview on 2/14/11 from 8:53 - 9:04 a.m., the LPN stated Individual #2 was on Abilify, lithium carbonate and trazodone prior to her employment with the facility.<br><br>The facility failed to ensure written informed consent was obtained for Individual #2's Abilify, lithium carbone, and trazodone.<br><br>3. Individual #3's record documented a 15 year old male diagnosed with mild mental retardation, obsessive compulsive disorder, and schizo-affective disorder. His record included a physician's order, dated 1/11/11, which documented he received 150 mg of trazodone (an antidepressant drug) nightly. The order further stated the start date of trazodone was 2/16/10.<br><br>However, Individual #3's record did not include documentation his guardian had given consent for the use of trazodone.<br><br>When asked, the Administrator stated during an interview on 2/11/11 from 10:30 a.m. - 12:25 p.m., consent was not documented due to an oversight.<br><br>The facility failed to ensure guardian approval was obtained prior to the use of trazodone for Individual #3.<br><br>4. Individual #4's record documented a 17 year | W 263 | | |

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| W 263 | Continued From page 75<br>old male diagnosed with mild mental retardation, oppositional defiant disorder, mood disorder NOS, bipolar disorder with psychosis, and PTSD. His record included a physician's order, dated 6/29/10, which documented he received Risperdal (an antipsychotic drug) 2 mg two times daily and 0.5 mg once daily.<br><br>Individual #4's record included a verbal HRC consent, dated 1/10/11, which included his guardian's signature on 1/12/11. However, there was no documentation his guardian had given consent for the use of the drug between 6/29/10 and 1/12/11.<br><br>When asked, the Administrator stated during an interview on 2/11/11 from 10:30 a.m. - 12:25 p.m., consent was not documented for the time period in question due to an oversight.<br><br>The facility failed to ensure guardian approval was obtained prior to the use of Risperdal for Individual #4. | W 263 | | |
| W 266 | 483.450 CLIENT BEHAVIOR & FACILITY PRACTICES<br><br>The facility must ensure that specific client behavior and facility practices requirements are met.<br><br>This CONDITION is not met as evidenced by:<br>Based on record review and staff interviews, it was determined the facility failed to ensure techniques used to manage inappropriate behavior were sufficiently developed, consistently implemented, and closely monitored. This failure resulted in individuals not receiving appropriate | W 266 | | |

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| W 266 | Continued From page 76<br>behavioral services and interventions. The findings include:<br><br>1. Refer to W214 as it relates to the facility's failure to ensure behavioral assessments were current, comprehensive, and accurately identified individuals' behavioral needs.<br><br>2. Refer to W227 as it relates to the facility's failure to ensure individuals' IPPs included objectives to meet their behavioral needs.<br><br>3. Refer to W239 as it relates to the facility's failure to ensure appropriate replacement behaviors were identified and incorporated into individuals' behavior intervention programs.<br><br>4. Refer to W252 as it relates to the facility's failure to ensure data was collected sufficiently to determine the efficacy of behavior intervention strategies.<br><br>5. Refer to W278 as it relates to the facility's failure to ensure an individual's record included evidence of least restrictive or more positive techniques being utilized prior to the use of more restrictive techniques to manage behavior.<br><br>6. Refer to W289 as it relates to the facility's failure to ensure techniques used to manage inappropriate behavior were sufficiently defined and incorporated into individuals' program plans.<br><br>7. Refer to W303 as it relates to the facilty's failure to ensure individuals' records documented a clear understanding of the events before, during, and after the use of restraint.<br><br>8. Refer to W312 as it relates to the facility's | W 266 | | |

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| W 266 | Continued From page 77<br>failure to ensure behavior modifying drugs were used only as a comprehensive part of individuals' IPPs that were directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed.<br><br>9. Refer to W313 as it relates to the facility's failure to ensure behavior modifying drugs were not used until the severity of the behavior was shown to outweigh the associated risks of the drugs. | W 266 | | |
| W 278 | 483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR<br><br>Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interviews, it was determined the facility failed to ensure individuals' records included evidence of least restrictive or more positive techniques being utilized prior to the use of more restrictive techniques to manage behavior for 1 of 4 individuals (Individual #2) whose restrictive interventions were reviewed. This resulted in the potential for an individual to be subjected to restrictive interventions unnecessarily. The findings include:<br><br>1. Individual #2's 5/10 IPP stated he was a 13 year old male whose diagnoses included bipolar mixed with psychotic features, ADHD, mild | W 278 | | |

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| W 278 | Continued From page 78<br>mental retardation, and mood disorder.<br><br>Individual #2's 2/11 MAR stated he received trazodone (an antidepressant drug) 50 - 150 mg PRN for insomnia.<br><br>His record included a psychiatric note, dated 1/31/11, which documented Individual #2's mother called the psychiatric provider and stated Individual #2 had woken up Saturday at midnight and did not go back to sleep until 7:00 a.m. The note further stated the trazodone order was clarified, but did not provide information on how.<br><br>During an interview on 2/11/11 from 10:30 a.m. - 12:25 p.m., the Administrator stated Individual #2's trazodone was new. The Administrator stated she believed the trazodone was added by the psychiatrist when Concerta was started due to concerns Concerta could cause insomnia.<br><br>Individual #2's record documented Concerta was started on 1/26/11. However, his 11/10 MAR documented he received his first dose of trazodone on 11/9/10, and his record contained a Telephone/Verbal Consent Form, dated 11/2/10, which stated trazodone was added due to Individual #2 having a "hard time going to bed at night." The record included no additional documentation regarding the use of trazodone.<br><br>Additionally, Individual #2's record did not include documentation that the facility had assessed his inability to sleep and attempt less restrictive interventions prior to the implementation of trazodone.<br><br>During an interview on 2/11/11 from 10:30 a.m. - 12:25 p.m., the Administrator stated there was no | W 278 | | |

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| W 278 | Continued From page 79<br>documentation of less restrictive interventions being tried before trazodone was implemented.<br><br>The facility failed to ensure less restrictive interventions had been systematically tried and proven to be ineffective prior to the use of trazodone for Individual #2. | W 278 | | |
| W 289 | 483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR<br><br>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interviews, it was determined the facility failed to ensure techniques used to manage inappropriate behavior were sufficiently defined and incorporated into the program plans for 2 of 4 individuals (Individuals #1 and #2) whose program records were reviewed. This resulted in a lack of appropriate interventions being in place to ensure individuals' behavioral needs were met. The findings include:<br><br>1. Individual #1's IPP, undated, stated he was a 12 year old male whose diagnoses included ADHD, PTSD, mild mental retardation, and impulse control disorder. He was admitted to the facility on 9/21/10.<br><br>Individual #1's PBSP included replacement behaviors for each identified maladaptive behavior. However, the plans did not include | W 289 | | |

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| W 289 | Continued From page 80<br>sufficient information as to direct staff in implementing the interventions as follows:<br><br>a. Individual #1's PBSP, dated 5/10, included an objective for task avoidance/defiance (defined as refusing to comply with staff requests or complete tasks). The Replacement Objective stated "Given direct verbal prompts, [Individual #1] will request a break during a non preferred task when he begins to show signs of anxiety..."<br><br>However, the plan did not include directions to staff on how to train Individual #1 to engage in the desired skill (i.e., through scenarios, options for refusal built into tasks not typically related to the maladaptive behavior, etc.) prior to engaging in the maladaptive behavior.<br><br>b. Individual #1's PBSP, dated 5/10, included an objective for verbal aggression/defiance (defined as yelling, swearing, or making derogative comments to staff or peers). The Replacement Objective stated "Given 2 direct verbal prompts or less, [Individual #1] will increase his appropriate interactions with staff when he is angry..."<br><br>However, the plan did not include directions to staff on how to train Individual #1 to engage in the desired skill (i.e., through scenarios, increasing communication skills, anger management training, etc.) prior to engaging in the maladaptive behavior.<br><br>c. Individual #1's PBSP, dated 5/10, included an objective for physical intimidation (defined as making threatening gestures to others, getting into the face of staff or peers, and using his size to intimidate others). The Replacement Objective stated "Given direct verbal prompts, [Individual | W 289 | | |

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| W 289 | Continued From page 81<br>#1] will comply with staff requests..."<br><br>However, the plan did not include directions to staff on how to train Individual #1 to engage in the desired skill (i.e., through scenarios, etc.) prior to engaging in the maladaptive behavior.<br><br>d. Individual #1's PBSP, dated 5/10, included an objective for physical aggression (defined as hitting, spitting, kicking, or biting when he is angry). The Replacement Objective stated "Given direct verbal prompts, talk to staff about his feelings when he begins to feel angry..."<br><br>However, the plan did not include directions to staff on how to train Individual #1 to engage in the desired skill (i.e., through scenarios, increasing communication skills, feeling identification, etc.) prior to engaging in the maladaptive behavior.<br><br>e. Individual #1's PBSP, dated 5/10, included an objective for tantrums (defined as throwing items around the room, crying uncontrollably, falling to the ground, and flinging arms around). The Replacement Objective stated "Given a direct verbal prompt or less, [Individual #1] will increase his appropriate interactions with staff..."<br><br>However, the plan did not include directions to staff on how to train Individual #1 to engage in the desired skill (i.e., through scenarios, increasing communication skills, anger management training, etc.) prior to engaging in the maladaptive behavior.<br><br>f. Individual #1's PBSP, dated 5/10, included an objective for property destruction (defined as breaking his toys or the facility's property while angry). The Replacement Objective stated | W 289 | | |

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| W 289 | Continued From page 82<br>"Given a direct verbal prompt or less, [Individual #1] will increase his instances of naming the emotion he is feeling to staff..."<br><br>However, the plan did not include directions to staff on how to train Individual #1 to engage in the desired skill (i.e., through scenarios, identifying emotions when not engaged in maladaptive behaviors, etc.) prior to engaging in the maladaptive behavior.<br><br>During an interview on 2/11/11 from 2:50 - 4:35 p.m., the QMRP, AQMRP and Administrator all stated replacement behaviors needed to be revised and for all individuals residing at the facility.<br><br>2. Individual #2's 5/10 IPP stated he was a 13 year old male whose diagnoses included bipolar mixed with psychotic features, ADHD, mild mental retardation, and mood disorder.<br><br>Individual #2's PBSP included replacement behaviors for each identified maladaptive behavior. However, the plans did not include sufficient information as to direct staff in implementing the interventions as follows:<br><br>a. Individual #2's PBSP, dated 5/10, included an objective for physical aggression towards others (defined as hitting, kicking, and/or spitting on those around him). The Replacement Objective stated "Given a direct verbal prompt or less, [Individual #2] will increase his instances of positive attention seeking (i.e. asking for attention verbally)..."<br><br>However, the plan did not include directions to staff on how to train Individual #2 to ask for | W 289 | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| W 289 | Continued From page 83<br>attention verbally.<br><br>b. Individual #2's PBSP, dated 5/10, included an objective for verbal assault to staff (defined as threatening staff with harm or cursing at staff when angry). The Replacement Objective stated "Given 2 direct verbal prompts or less, [Individual #2] will increase his appropriate interactions with staff..."<br><br>However, the plan did not include directions to staff on how to train Individual #2 to engage in the desired skill (i.e., through scenarios, increasing communication skills, anger management training, etc.) prior to engaging in the maladaptive behavior.<br><br>c. Individual #2's PBSP, dated 5/10, included an objective for teasing/provoking other residents (defined as poking residents with his finger, taunting other residents who are in restraint, or doing things that others do not like in order to "get a reaction from the resident"). The Replacement Objective stated "Given 2 direct verbal prompts, [Individual #2] will increase his appropriate interactions with the other residents..."<br><br>However, the plan did not include directions to staff on how to train Individual #2 to engage in the desired skill (i.e., through scenarios, boundary training, increasing communication skills, anger management training, etc.) prior to engaging in the maladaptive behavior.<br><br>d. Individual #2's PBSP, dated 5/10, included an objective for property destruction (defined as breaking his toys or the facility property). The Replacement Objective stated "Given a direct verbal prompt or less, [Individual #2] will increase | W 289 | | |

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| W 289 | Continued From page 84<br>his instances of talking about his anger to staff..."<br><br>However, the plan did not include instructions to staff on how to train Individual #2 to engage in the desired skill (i.e., through scenarios, increasing communication skills, anger management skills, etc.) prior to engaging in the maladaptive behavior.<br><br>e. Individual #2's PBSP, dated 5/10, included an objective for tantrums (defined as falling to the ground kicking, crying and screaming). The Replacement Objective stated "Given a direct verbal prompt or less, [Individual #2] will increase his appropriate interactions with staff..."<br><br>However, the plan did not include directions to staff on how to train Individual #2 to engage in the desired skill (i.e., through scenarios, increasing communication skills, anger management training, etc.) prior to engaging in the maladaptive behavior.<br><br>f. Individual #2's PBSP, dated 5/10, included an objective for sexually inappropriate behaviors (poking female staff in the breast area and making inappropriate sexual comments or gestures). The Replacement Objective stated "Given a direct verbal prompt or less, [Individual #2] will increase his communication skills to get the things that he wants..."<br><br>However, the plan did not include directions to staff on how to train Individual #2 to engage in the desired skill (i.e., through scenarios, communication skills training, etc.) prior to engaging in the maladaptive behavior.<br><br>During an interview on 2/11/11 from 2:50 - 4:35 | W 289 | | |

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| W 289 | Continued From page 85<br>p.m., the QMRP, AQMRP and Administrator all stated replacement behaviors needed to be revised and for all individuals residing at the facility.<br><br>3. Individual #3's record documented a 15 year old male diagnosed with mild mental retardation, obsessive compulsive disorder, and schizo-affective disorder.<br><br>Individual #3's PBSP included replacement behaviors for each identified maladaptive behavior. However, the plans did not include sufficient information as to direct staff in implementing the interventions as follows:<br><br>a. Individual #3's PBSP, dated 5/10, included an objective for physical aggression (defined as hitting and kicking staff and other residents). The Replacement Objective stated "[Individual #3] will have 3 or more instances per month of discussion [sic] his anger with staff when he becomes angry or upset with those around him."<br><br>However, the plan did not include directions to staff on how to train Individual #3 to engage in the desired skill (i.e., through scenarios, increasing communication skills, anger management training, etc.) prior to engaging in the maladaptive behavior.<br><br>b. Individual #3's PBSP, dated 5/10, included an objective for refusal (defined as verbally refusing to complete a task). The Replacement Objective stated "When given a verbal prompt or less, [Individual #3] will complete his required tasks without refusals 5 out of 7 trials per month."<br><br>However, the plan did not include directions to | W 289 | | |

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| W 289 | Continued From page 86<br>staff on how to train Individual #3 to engage in the desired skill (i.e., through scenarios, appropriate refusal techniques, etc.) prior to engaging in the maladaptive behavior.<br><br>c. Individual #3's PBSP, dated 5/10, included an objective for difficulty falling asleep (defined as "acting restless at bedtime and having difficulty falling asleep"). The Replacement Objective stated "When given direct verbal prompts, [Individual #3] will stay in his bed when prompted to go to sleep at the appropriate hours in 80% of trials."<br><br>However, the plan did not include directions to staff on how to train Individual #3 to engage in the desired skill (i.e., through scenarios, sleep hygiene training, etc.) prior to engaging in the maladaptive behavior.<br><br>When asked, the QMRP, AQMRP, and Administrator all stated, during an interview on 2/11/11 from 2:50 - 4:35 p.m., Individual #3's replacement behaviors needed to be revised.<br><br>The facility failed to ensure appropriate replacement behaviors were developed for Individual #3.<br><br>4. Individual #4's record documented a 17 year old male diagnosed with mild mental retardation, ODD, mood disorder NOS, bipolar disorder with psychosis, and PTSD.<br><br>a. Individual #4's PBSP, dated 5/10, included an objective for physical intimidation (defined as "making threatening gestures, getting into the face of staff or peers, and using physical stature to intimidate others"). The Replacement | W 289 | | |

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| W 289 | Continued From page 87<br>Objective stated "Given direct verbal prompts, [Individual #4] will comply with staff requests in 50% of trials per month."<br><br>However, the plan did not include directions to staff on how to train Individual #4 to engage in the desired skill (i.e., through scenarios, increasing communication skills, anger management training, etc.) prior to engaging in the maladaptive behavior.<br><br>b. Individual #4's PBSP, dated 5/10, included an objective for restlessness/difficulty falling asleep (defined as "becoming more awake and restless as it gets closer to night time"). The Replacement Objective stated "Given direct verbal prompts, [Individual #4] will comply with staff prompts to go to bed."<br><br>However, the plan did not include directions to staff on how to train Individual #4 to engage in the desired skill (i.e., through scenarios, sleep hygiene training, etc.) prior to engaging in the maladaptive behavior.<br><br>When asked, the QMRP, AQMRP, and Administrator all stated, during an interview on 2/11/11 from 2:50 - 4:35 p.m., Individual #4's replacement behaviors needed to be revised.<br><br>The facility failed to ensure Individuals #1 - #4's plans included sufficient information to allow staff to implement their behavioral interventions. | W 289 | | |
| W 303 | 483.450(d)(4) PHYSICAL RESTRAINTS<br><br>A record of restraint checks and usage must be kept. | W 303 | | |

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| W 303 | Continued From page 88<br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interviews, it was determined the facility failed to ensure individuals' records documented a clear understanding of the events before, during, and after the use of restraint for 4 of 4 individuals (Individuals #1 - #4) whose records documented the use of restraints. Failure to keep a comprehensive record of restraint usage impeded the IDT's, the facility's HRC, and individuals' guardians ability to make informed decisions and/or recommendations regarding the use of restraint. Findings include:<br><br>1. The facility utilized a Restraint Report Sheet that included a grid that allowed staff to document time in and time out of the restraint, whether the restraint was part of a program, emergency, or a medical/PRN restraint, the type of restraint used including CPI-1 staff, CPI-2 staff, or mechanical, and a section to document 30 minute checks. Under the grid were questions related to the antecedent, behavior, and consequence of the behavior, as well as a place to document steps staff took to avoid the restraint and any injuries incurred during the restraint.<br><br>The facility's Restraint Report Sheets from 9/1/10 - 1/31/11 were reviewed. The Restraint Report Sheets did not contain sufficient data as follows:<br><br>a. Individual #1's IPP, undated, stated he was a 12 year old male whose diagnoses included ADHD, PTSD, mild mental retardation, and impulse control disorder. He was admitted to the facility on 9/21/10. Individual #1's PBSP, dated 5/10, documented he could receive up to a CPI Team Restraint (undefined). | W 303 | | |

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| W 303 | Continued From page 89<br>Individual #1's Restraint Report Sheets did not include sufficient information. Examples included, but were not limited to, the following:<br><br>- 9/22/10: Individual #1 was restrained from 6:30 - 7:00 a.m. The form did not document the type of restraint used. The form stated Individual #1 was hitting and spitting on staff and trying to use a fishhook to harm another individual. The form did not include clear information related to the events before, during, and after the restraint.<br><br>- 9/23/10: Individual #1 was restrained from 9:00 - 9:40, a.m./p.m. not indicated. The form did not document the type of restraint used or if 30 minute checks had been completed. The form stated Individual #1 did not want to go to bed and hit, kicked, and punched staff, hit his head on a wall, and was bitting. The form did not include clear information related to the events before, during, and after the restraint.<br><br>- 10/8/10: Individual #1 was restrained at 7:05, a.m./p.m. not indicated. The form did not document how long the restraint lasted or the type of restraint used. The form stated Individual #1 was cued to clean his room, got mad and started to yell, kicked staff, and was assisted to his room. The form did not include clear information related to the events before, during, and after the restraint.<br><br>- 10/10/10: Individual #1 was restrained from 9:00 - 10:00, a.m./p.m. not indicated. The form did not document the type of restraint used or if 30 minute checks had been completed. The form stated Individual #1 was yelled at by another individual, hit staff, was assisted to his room, and scratched, kicked, and tried to bite staff. The | W 303 | | |

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| W 303 | Continued From page 90<br>form did not include clear information related to the events before, during, and after the restraint.<br><br>- 11/18/10: Individual #1 was placed in a CPI-2 staff restraint. The time in/time out for the restraint was not documented. The form stated Individual #1 was cued to go to bed, threw items, hit staff, and hit himself and the walls. The form did not include clear information related to the events before, during, and after the restraint.<br><br>- 1/14/11: Individual #1 was restrained from 7:15 - 7:17, a.m./p.m. not indicated. The form did not document the type of restraint used. The form stated Individual #1 threw a remote control and hit and kicked staff. The form did not include clear information related to the events before, during, and after the restraint.<br><br>- 1/19/11: Individual #1 was restrained. The form did not document the time in/time out of the restraint and did not document the type of restraint used. The form stated Individual #1 refused to go to bed, was spitting, and threw a chair. The corresponding ABC form stated Individual #1 threw a chair at the door in his room at which time "staff went into the Room and Gave [Individual #1] a Restraint [sic]." The form did not include clear information related to the events before, during, and after the restraint.<br><br>During an interview on 2/11/11 from 2:50 - 4:35 p.m., the Administrator and QMRP both stated the AQMRP was reviewing restraint data and the QMRP was supposed to review the restraint data. The Administrator and QMRP both stated the missing information should have been identified and questioned. The QMRP stated there was not sufficient information present to evaluate the | W 303 | | |

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| W 303 | Continued From page 91<br>effectiveness for the restraint and ensure proper use.<br><br>b. Individual #2's 5/10 IPP stated he was a 13 year old male whose diagnoses included bipolar mixed with psychotic features, ADHD, mild mental retardation, and mood disorder. His PBSP, dated 5/10, documented he could receive up to a CPI Team Restraint (undefined).<br><br>Individual #2's Restraint Report Sheets did not include sufficient information. Examples included, but were not limited to, the following:<br><br>- 9/23/10: Individual #2 was restrained from 7:20 - 7:22, a.m./p.m. not indicated. The form did not document the type of restraint used. The form stated individual #2 hit staff in the back, punched staff, and kicked staff. The form did not include clear information related to the events before, during, and after the restraint.<br><br>- 9/26/10: Individual #2 was restrained from 11:40 - 12:00, a.m./p.m. not indicated. The form did not document the type of restraint used. The form stated Individual #2 got mad when another individual was mowing the lawn and hit, spit, and cursed at staff. The form did not include clear information related to the events before, during, and after the restraint.<br><br>- 10/15/10: Individual #2 was restrained. The form did not document the time in/time out of the restraint, and did not document the type of restraint used. The form stated Individual #2 hit, pinched, and spit on staff and threatened another individual. The form did not include clear information related to the events before, during, and after the restraint. | W 303 | | |

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| W 303 | Continued From page 92<br><br>- 10/21/10: Individual #2 was restrained. The form did not document the time in/time out of the restraint, and did not document the type of restraint used. The form stated Individual #2 attempted to kick staff, threw items, and punched his wall. The form did not include clear information related to the events before, during, and after the restraint.<br><br>- 11/7/10: Individual #2 was restrained from 5:45 - 6:05, a.m./p.m. not indicated. The form did not document the type of restraint used. The form stated Individual #2 was swearing at others, was redirected to his room and began hitting walls and doors, throwing items, and hitting staff. The form did not include clear information related to the events before, during, and after the restraint.<br><br>- 12/1/10: Individual #2 was restrained. The form did not document the time in/time out of the restraint and did not document the type of restraint used. The form stated Individual #2 was hitting and kicking staff. The form did not include clear information related to the events before, during, and after the restraint.<br><br>- 1/1/11: Individual #2 was restrained from 10:15 - 10:30, a.m./p.m. not indicated. The form did not document the type of restraint used. The form stated Individual #2 was screaming and tried to bite, hit, and kick staff. The form did not include clear information related to the events before, during, and after the restraint.<br><br>- 1/3/11: Individual #2 was restrained. The form did not document the time in/time out of the restraint, and did not document the type of restraint used. The form stated Individual #2 was | W 303 | | |

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| W 303 | Continued From page 93<br>spitting and kicking staff, kicked the face plate off an air conditioner, and threw the face plate at staff. The form did not include clear information related to the events before, during, and after the restraint.<br><br>During an interview on 2/11/11 from 2:50 - 4:35 p.m., the Administrator and QMRP both stated the AQMRP was reviewing restraint data and the QMRP was supposed to review the restraint data. The Administrator and QMRP both stated the missing information should have been identified and questioned. The QMRP stated there was not sufficient information present to evaluate the effectiveness for the restraint and ensure proper use.<br><br>3. Individual #3's record documented a 15 year old male diagnosed with mild mental retardation, obsessive compulsive disorder, and schizo-affective disorder. His PBSP, dated, 5/10, documented he could receive a team restraint (undefined) until he was calm.<br><br>Individual #3's Restraint Report Sheets did not include sufficient information. Examples included, but were not limited, to the following:<br><br>- 9/11/10: Individual #3 was restrained from 11:30 - 11:45, a.m./p.m. not indicated. However, the corresponding ABC form documented Individual #3 was placed in restraint 3 times during that time period.<br><br>- 9/22/10: Individual #3 was restrained from 8:00 - 8:50 p.m. The form did not document the type of restraint used or include evidence of 30 minute checks. Additionally, the corresponding ABC form documented Individual #3 was placed in | W 303 | | |

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| W 303 | Continued From page 94<br>restraint twice during this time period.<br><br>- 11/17/10: Individual #3 was restrained from 7:00 - 7:30, a.m. or p.m. not indicated. The form did not document the type of restraint used.<br><br>- 1/20/11: Individual #3 was restrained. However, the form did not document time in/out or type of restraint used.<br><br>When asked, the QMRP stated during an interview on 2/11/11 from 2:50 - 4:35 p.m. the information documented on the Restraint Report Sheets was not sufficient.<br><br>4. Individual #4's record documented a 17 year old male diagnosed with mild mental retardation, ODD, mood disorder NOS, bipolar disorder with psychosis, and PTSD. His PBSP, dated 5/20 documented he could receive a CPI Team Restraint (undefined) until he no longer posed a threat to himself or others.<br><br>Individual #4's Restraint Report Sheets did not include sufficient information. Examples included, but were not limited, to the following:<br><br>- 10/7/10: Individual #4 was restrained from 10:00 - 10:11 a.m. However, the form did not document what type of restraint was used. The form did not include clear information related to the events before, during, and after the restraint.<br><br>- 10/20/10: Individual #4 was placed in a CPI-2 staff restraint from 3:30 - 4:20 p.m. The form did not document 30 minute checks. The form did not include clear information related to the events before, during, and after the restraint. | W 303 | | |

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| W 303 | Continued From page 95<br>When asked, the QMRP stated during an interview on 2/11/11 from 2:50 - 4:35 p.m. the information documented on the Restraint Report Sheet was not sufficient.<br><br>The facility failed to ensure accurate and sufficient documentation of restraints was kept for Individuals #1 - #4. | W 303 | | |
| W 312 | 483.450(e)(2) DRUG USAGE<br><br>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interviews, it was determined the facility failed to ensure behavior modifying drugs were used only as a comprehensive part of individuals' IPPs that were directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed for 2 of 4 individuals (Individual #1 and #2) whose medication reduction plans were reviewed. This resulted in individuals receiving behavior modifying drugs without plans that identified the drugs usage and how they may change in relation to progress or regression. The findings include:<br><br>1. Individual #1's IPP, undated, stated he was a 12 year old male whose diagnoses included ADHD, PTSD, mild mental retardation, and impulse control disorder. He was admitted to the facility on 9/21/10. | W 312 | | |

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| | 13G078 | A. BUILDING _____ B. WING _____ | C 02/14/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HOME AGAIN ICF | 2311 ARUBA DRIVE NAMPA, ID 83686 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| W 312 | Continued From page 96<br>Individual #1's 1/11 MAR stated he received Strattera (a central nervous system drug) 40 mg daily for ADHD, topiramate (an anticonvulsant drug) 25 mg daily for PTSD, divalproex sodium (an anticonvulsant drug) 500 mg daily for mood control, and guanfacine HCL (an antihypertensive drug) 2 mg daily for ADHD.<br><br>However, Individual #1's record did not include plans that identified the drugs usage and how they may change in relation to progress or regression.<br><br>During an interview on 2/11/11 from 2:50 - 4:35 p.m., the Administrator stated Individual #1's medication reduction plans had not been developed due to an oversight.<br><br>The facility failed to ensure Individual #1's Strattera, topiramate, divalproex sodium, and guanfacine HCL were appropriately incorporated into a plan.<br><br>2. Individual #2's 5/10 IPP stated he was a 13 year old male whose diagnoses included bipolar mixed with psychotic features, ADHD, mild mental retardation, and mood disorder.<br><br>Individual #2's 2/11 MAR stated he received Abilify (an antipsychotic drug) 15 mg daily for aggression/agitation, Concerta (a central nervous system drug) 54 mg daily for ADHD, trazodone (an antidepressant drug) 50 - 150 mg PRN for insomnia, divalproex sodium (an anticonvulsant drug) 1500 mg daily for aggression, and lithium carbonate (an antipsychotic drug) 1200 mg daily for aggression.<br><br>Individual #2's PBSP, dated 5/10, included | W 312 | | |

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| W 312 | Continued From page 97<br>information related to the use of divalproex sodium and lithium carbonate. However, the plan did not include the use of Abilify, Concerta, or trazodone. No additional documentation related to the use of those drugs could be found in Individual #2's record.<br><br>During an interview on 2/11/11 from 10:30 a.m. - 12:25 p.m., the Administrator stated there was not a medication reduction plan for Abilify, Concerta or trazodone for Individual #2.<br><br>The facility failed to ensure Individual #2's Abilify, Concerta and trazodone were appropriately incorporated into a plan. | W 312 | | |
| W 313 | 483.450(e)(3) DRUG USAGE<br><br>Drugs used for control of inappropriate behavior must not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs.<br><br>This STANDARD is not met as evidenced by:<br>Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were not used until the severity of the behavior was shown to outweigh the associated risks of the drugs for 1 of 4 individuals (Individual #2) whose restrictive interventions were reviewed. This resulted in an individual receiving behavior modifying drugs without the necessary justification. The findings include:<br><br>1. Individual #2's 5/10 IPP stated he was a 13 year old male whose diagnoses included bipolar mixed with psychotic features, ADHD, mild mental retardation, and mood disorder. His Physician's Order Form, dated 1/11/11, stated he | W 313 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| W 313 | Continued From page 98<br>received Concerta (a central nervous system drug) 54 mg daily.<br><br>Individual #2's record contained a Telephone/Verbal Consent Form, dated 1/24/11, which stated Concerta was for making "whoop" noises and verbal assault.<br><br>The Nursing 2011 Drug Handbook stated the side effects of Concerta included, but were not limited to, nervousness, headache, insomnia, seizures, dizziness, akathisia (restless leg syndrome), dyskinesia (diminished voluntary movement and increased involuntary movement), mood swings, palpitations, tachycardia (rapid heart beat), arrhythmias (abnormal heart beat), hypertension (high blood pressure), nausea, abdominal pain, vomiting, thrombocytopenic purpura (low blood platelets), leukopenia (decreased white blood count), upper respiratory tract infection, erythema (rash), and viral infection.<br><br>Individual #2's record did not contain documented evidence that his making "whoop" noises and verbal assaults outweighed the potentially harmful effects of Concerta.<br><br>During an interview on 2/11/11 from 2:50 - 4:35 p.m., the Administrator stated the drug was actually for ADHD exhibited by other behaviors in addition to making "whoop" noises, but ADHD was not defined or described in Individual #2's record. The Administrator stated there was not documented evidence that showed the risk of Individual #2's behavior outweighed the potentially harmful effects of Concerta.<br><br>The facility failed to ensure the risks of Individual #2's maladaptive behavior outweighed the | W 313 | | |

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| W 313 | Continued From page 99<br>potential side effects of Concerta. | W 313 | | |

Bureau of Facility Standards

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| MM177 | 16.03.11.075.09 Protection from Abuse and Restraint<br><br>Protection from Abuse and Unwarranted Restraints. Each resident admitted to the facility must be protected from mental and physical abuse, and free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time, or when necessary in an emergency to protect the resident from injury to himself or to others (See also Subsection 075.10).<br>This Rule is not met as evidenced by:<br>Refer to W122, W149, W153, W154 and W157. | MM177 | for all corrections see Plan of Corrections Attached | |
| MM182 | 16.03.11.075.09 (a)(iv) Resident placed in Restraints<br><br>The written policy and procedures governing the use of restraints must specify which staff member may authorize use of restraints and clearly delineate at least the following:<br>A resident placed in restraint must be checked at least every thirty (30) minutes by appropriately trained staff and an account of this surveillance must be kept; and<br>This Rule is not met as evidenced by:<br>Refer to W303. | MM182 | RECEIVED MAR 0 9 2011 FACILITY STANDARDS | |
| MM192 | 16.03.11.075.09 (d) Drugs<br><br>Drugs such as tranquilizers must not be used as chemical restraints to limit or control resident behavior for convenience of staff.<br>This Rule is not met as evidenced by:<br>Refer to W278. | MM192 | | |
| MM194 | 16.03.11.075.10(a) Approval of Human Rights | MM194 | | |

Bureau of Facility Standards

TITLE Admin. (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| MM194 | Continued From page 1<br>Committee<br><br>Has been reviewed and approved by the facility's human rights committee; and<br>This Rule is not met as evidenced by:<br>Refer to W262. | MM194 | | |
| MM196 | 16.03.11.075.10(c) Consent of Parent or Guardian<br><br>Is conducted only with the consent of the parent or guardian, or after notice to the resident's representative; and<br>This Rule is not met as evidenced by:<br>Refer to W263. | MM196 | | |
| MM197 | 16.03.11.075.10(d) Written Plans<br><br>Is described in written plans that are kept on file in the facility; and<br><br>This Rule is not met as evidenced by:<br>Refer to W289 and W312. | MM197 | | |
| MM212 | 16.03.11.075.17(a) Maximize Developmental Potential<br><br>The treatment, services, and habilitation for each resident must be designed to maximize the developmental potential of the resident and must be provided in the setting that is least restrictive of the resident's personal liberties; and<br>This Rule is not met as evidenced by:<br>Refer to W266. | MM212 | | |

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| MM725 | Continued From page 2 | MM725 | | |
| MM725 | 16.03.11.270.01(b) QMRP<br><br>The QMRP is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the program, recording each resident's progress and initiating periodic review of each individual plan for necessary modifications or adjustments. This function may be provided by a QMRP outside the facility, by agreement.<br><br>This Rule is not met as evidenced by:<br>Refer to W159. | MM725 | | |
| MM729 | 16.03.11.270.01(d) Treatment Plan Objectives<br><br>The individual treatment plan must state specific objectives to reach identified goals. The objectives must be:<br>This Rule is not met as evidenced by:<br>Refer to W227. | MM729 | | |
| MM730 | 16.03.11.270.01(d)(i) Diagnostic and Prognostic Data<br><br>Based on complete and relevant diagnostic and prognostic data; and<br>This Rule is not met as evidenced by:<br>Refer to W214 and W252. | MM730 | | |
| MM855 | 16.03.11.270.08(c) Training and Habilitation Record<br><br>There must be a functional training and habilitation record for each resident maintained by and available to all training and habilitation staff which shows evidence of training and | MM855 | | |

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| MM855 | Continued From page 3<br>habilitation service activities designed to meet the objectives set for every resident.<br>This Rule is not met as evidenced by:<br>Refer to W239. | MM855 | | |

# Home Again ICF Plan of Corrections dated 3/2/2011

***Key:***

***QMRP – Qualified Mental Retardation Professional***
***LCSW - Licensed Clinical Social Worker***
***LPN – Licensed Practical Nurse***
***IPP – Individual Program Plan***
***FUBA – Functional Behavior Assessment***
***AQMRP – Assistant Qualified Mental Retardation Professional***
***RN – Registered Nurse***
***ABC – Antecedent, Behavior, Consequence***
***PBSP – Positive Behavior Support Plan***

1. ***Describe what corrective actions will be accomplished for those individuals found to have been affected by the deficient practice.***
2. ***Describe how the facility will identify other individuals having the potential to be affected by the same deficient practice and what corrective actions and what corrective actions will be taken.***
3. ***Describes what measures will be put into place or what systematic change will be made to ensure that the deficient practice does not reoccur. How will the corrective actions be monitored to ensure that the deficient practice will not reoccur, ie. What quality assurance program will be put into place.***
4. ***What is the date that the corrective actions will be completed?***



**W122** refer to plan of corrections for W149

**W149**

1. (1-2.) As stated in the immediate plan of correction, all staff were trained prior to working with the residents that any individual who voiced suicidal ideation or made any type of suicidal gesture would be immediately placed on suicide watch with a 1:1 arm's length staff, a scale of suicidal ideation would be completed by trained staff and the results immediately called to the Licensed Clinical Social Worker (LCSW), the LCSW would gather any additional information needed, the direct care staff would follow the directions of the LCSW to ensure the safety of the resident.
3. The RN and QMRP will be trained by the LCSW in assessment and protection of residents who have shown suicidal ideation. Our suicide policy is being amended by the administrator to ensure that residents are protected from potential dangers and that suicidal ideation is sufficiently assessed and monitored.
4. These changes will have been completed as of 3/9/11.

**W153**

1. The Administrator retrained the staff members responsible for late notifications of abuse on the importance of immediate notification of any allegation of abuse or neglect.
2. All Home Again ICF staff were reminded of the Home Again ICF Abuse Policy and specifically the importance of immediate notification per the policy.
3. Any future instances of late notification of an abuse allegation will be investigated by the administrator and the staff member responsible will be reprimanded and retrained.
4. These changes will have been completed as of 3/16/11.

**W154**

1. The Administrator all of the investigations that occurred after July 2010 and ensure that lack of thorough documentation did not result in any harmful effects to the residents.
2. The Admiistrator will review all significant event forms and restraint forms to ensure that no investigations should have been conducted but were not and will complete investigations if indicated.
3. The procedure for investigations has been changed to require complete documentation of all investigations into any allegation or suspicion of abuse or neglect. This documentation includes a detailed account of the allegation, witness

statements, documentation of interviews, notifications, any corrective actions taken, and the conclusion, including names and dates. The administrator will review all investigations to ensure they are complete and have been thoroughly documented.

4. These changes have been made as of 3/9/10.

**W157**

1. (1-2) The QMRP and AQMRP will review all of the investigations that occurred after July 2010 and document any corrective actions that took place to correct those issues and/or make corrective actions to address any issues as indicated.
3. The investigation procedure now includes a specific place to document all corrective actions taken as a result of the investigation including a detailed account of the allegation, witness statements, documentation of interviews including what questions were asked, any corrective action taken, notifications, and the conclusion. This information will include names and dates. The administrator will review all investigations to ensure they are complete and have been thoroughly documented.
4. These changes have been made as of 3/9/10.

**W159**

1. (1-2) The administrator has trained the new QMRP on the importance of consistent monitoring of behavior documentation and interventions for all residents.
3. The document titled QMRP Notes is being updated for the month of February for all residents to show the percentage of success and number of trials and any applicable comments regarding the progress of the resident. The information on mal-adaptive behaviors required in the narratives documented in the new QMRP Notes and Behavior Documentation Form. In this form, it states the total number of incidents for all inappropriate behaviors exhibited by the resident in that month, if the inappropriate behavior is increasing or decreasing in frequency and/or severity, if a resident has met the criteria for reducing the medication tied to a specific behavior, whether the instances of each type of behavior happened evenly throughout the month or whether most instances happened during one week or day in the month, and if any patterns have been found: for example does the behavior happen most often in a specific time of day or on a specific day of the week, or during a specific activity. The AQMRP will document any new or emerging behaviors and will notify the QMRP that these behaviors need to be assessed.

   The behavior tallying has been updated to include only the behaviors currently being targeted with definitions of those behaviors and new or emerging behaviors will be added to the form to ensure that all mal-adaptive behaviors that are in the residents Positive Behavior Support Plans are being monitored and that new and emerging behaviors are identified early. Any behaviors identified on the past Behavior Tally Form that are not included in the resident's FUBA and PBSP have been assessed and included in the PBSP.

   All administrative staff have been trained in the new policy titled Behavior Documentation and Behavior Modifying Medication that has been added to the policy and procedure manual. This procedure gives detailed instructions on how mal-adaptive behaviors will be documented, monitored, and addressed. It also gives detailed instructions on how to prepare a detailed report to take to a medication management appointment. This report will include the following information: What behaviors have been documented since the last visit? How many times have the behaviors occurred? Have the instances happened throughout the month or did most happen in one day or week? If so what happened in that week or day? Have the instances of the behavior been more severe or less severe since the last visit? Is there an assessment and plan for this behavior or is it new or emerging? What less restrictive interventions have been tried to address this behavior? Could this behavior be reduced by changing the environment? Is this behavior occurring as a reaction to a change or something happening in the resident's environment? Is there a plan in place to help the resident deal with the change? Is this change something we can control or change? Is this a change that is temporary or seasonal?

Does the IDT feel that the change in behavior (s) indicates a need for a change in the medication? Has the resident met the objective set out to reduce the attending medication?

The IDT including the QMRP, AQMRP, and the LPN will assess the identified mal-adaptive behaviors documented for all residents to ensure that all of the information required above is available for all of the behaviors for the month of February. This information will be included in February's updated QMRP Notes.

A new sleep documentation form is now being used for all residents to document the number of hours the resident sleeps and incidents of restlessness or wakefulness in the night. The QMRP and LPN will monitor the documentation of the resident's sleep to assess the need for any changes to the objectives or medication.

4. These changes will be made by 3/9/2011..

**W166** - refer to the plan of correction for W149

**W214**

1. For individual #1, the resident's functional behavior assessment (FUBA) has been updated to include their Psychiatric Diagnosis, behavior modifying medications, and how those diagnosis affect the mal-adaptive behaviors. The new information in the FUBA for individual #1 will be used to update their Positive Behavior Support Plan (PBSP) to ensure continuity between the assessment and the interventions. Mal-adaptive sexual behaviors will be added to the FUBA of individual #1 and incorporated into the PBSP. The environmental factor of moving will be removed from the IPP because the assessment showed that it is no longer a contributing factor.

   For individual #2, the resident's functional behavior assessment (FUBA) is being updated to include their Psychiatric Diagnosis, behavior modifying medications, and how those diagnosis affect the mal-adaptive behaviors. Information is being included in the FUBA for individual #2 regarding the enjoyment that this resident is observed to experience from upsetting others and trying to get others in trouble. A behavior assessment for Running Away, sexually inappropriate behaviors, physical intimidation, task avoidance, and Suicidal Ideation will be completed in the resident's FUBA. The new information in the FUBA for individual #2 will be used to update their Positive Behavior Support Plan (PBSP) to ensure continuity between the assessment and the interventions.

   For individual #3, the resident's functional behavior assessment (FUBA) will be updated to include their Psychiatric Diagnosis, behavior modifying medications, and how those diagnosis affect the mal-adaptive behaviors. The FUBA will be updated to include agitation, physical intimidation, emotional outbursts (which includes verbal aggression), task avoidance, and property destruction. The resident has not demonstrated inappropriate sexual behaviors since admittance, so that behavior is no longer being monitored. If it occurs again it will be treated as a re-emerging behavior and will be included in the FUBA and PBSP. The assessment of restlessness will be broadened to include insomnia and a new sleep documentation form was instituted to document hours of sleep and incidents of restlessness and insomnia in the night. The new information in the FUBA for individual #3 will be used to update their Positive Behavior Support Plan (PBSP) to ensure continuity between the assessment and the interventions.

   For individual #4, the resident's functional behavior assessment (FUBA) will be updated to include their Psychiatric Diagnosis, behavior modifying medications, and how those diagnosis affect the mal-adaptive behaviors. The FUBA will be updated to include agitation and hyper-activity. A new sleep documentation form was instituted to document hours of sleep and incidents of restlessness and insomnia in the night. A review of the ABC data revealed that emotional outbursts for this resident consisted of verbal aggression/intimidation and physical intimidation which are both assessed on the FUBA so the behaviors will not be documented as verbal aggression/intimidation or physical intimidation rather than emotional outburst. The new information in the FUBA for individual #4 will be used to update their Positive Behavior Support Plan (PBSP) to ensure continuity between the assessment and the interventions. Mal-adaptive sexual behaviors will be added to the FUBA of individual #4 and incorporated into the PBSP. The behaviors of refusing to attend school and socially offensive

behaviors has been removed from the FUBA and PBSP because these behaviors have not been displayed for more than 6 months. If they occurs again it will be treated as a re-emerging behavior and will be included in the FUBA.

2. The FUBA and PBSP for all residents will be updated to include their Psychiatric Diagnosis, behavior modifying medications, and any environmental factors and how those things affect the mal-adaptive behaviors. All documented exhibited mal-adapted behaviors will be included in the FUBA and PBSP for each resident and behaviors that have not occurred in 6 months have been removed. The new information in the FUBA for all residents will be used to update their Positive Behavior Support Plan (PBSP) to ensure continuity between the assessment and the interventions. A new sleep documentation form was instituted to document hours of sleep and incidents of restlessness and insomnia in the night for all residents to monitor for existing or new sleep issues as those residents who do not take medications to help them sleep do have differences in sleep as side effects of their medications. This will be completed by the IDT including The QMRP, the AQMRP, the LPN, the administrator, the residents, and other members as indicated.
3. The QMRP will monitor the behavior documentation and will update the FUBA and PBSP as needed to reflect major changes in the resident's behaviors or any new or emerging behaviors.
4. These changes will be made by 3/9/2011.

**W227**

1. For individual #2, the resident's functional behavior assessment (FUBA) will be updated to include their Psychiatric Diagnosis, behavior modifying medications, and how those diagnosis affect the mal-adaptive behaviors. Information will be included in the FUBA for individual #2 regarding the enjoyment that this resident is observed to experience from upsetting others and trying to get others in trouble. A behavior assessment for Running Away, sexually inappropriate behaviors, physical intimidation, task avoidance, and Suicidal Ideation will be completed in the resident's FUBA. An assessment of emotional outbursts revealed that it fit into the definition for tantrums which has an assessment and objective, so this behavior is now being documented as tantrum and not emotional outbursts. The new information in the FUBA for individual #2 will be used to update their Positive Behavior Support Plan (PBSP) to ensure continuity between the assessment and the interventions. New IPP objectives will be added for running Away, sexually inappropriate behaviors, physical intimidation, task avoidance, and Suicidal Ideation based on the behavior assessments for those behaviors in the FUBA.

   For individual #1, the resident's functional behavior assessment (FUBA) will be updated to include their Psychiatric Diagnosis, behavior modifying medications, and the environmental factor of moving and how those diagnosis affect the mal-adaptive behaviors. The new information in the FUBA for individual #1 will be used to update their Positive Behavior Support Plan (PBSP) to ensure continuity between the assessment and the interventions. Mal-adaptive sexual behaviors will be added to the FUBA of individual #1 and incorporated into the PBSP and a new objective was created for this behavior.

   For individual #3, the resident's functional behavior assessment (FUBA) was updated to include their Psychiatric Diagnosis, behavior modifying medications, and how those diagnosis affect the mal-adaptive behaviors. The FUBA was updated to include agitation, physical intimidation, emotional outbursts (which includes verbal aggression), task avoidance, and property destruction. New PBSP objectives were created for these behaviors based on the information in the FUBA. The resident has not demonstrated inappropriate sexual behaviors since admittance, so that behavior is no longer being monitored. If it occurs again it will be treated as a re-emerging behavior and will be included in the FUBA. The assessment of restlessness was broadened to include insomnia and a new sleep documentation form was instituted to document hours of sleep and incidents of restlessness and insomnia in the night. The new information in the FUBA for individual #3 was used to update their Positive Behavior Support Plan (PBSP) to ensure continuity between the assessment and the interventions.

   For individual #4, the resident's functional behavior assessment (FUBA) was updated to include their Psychiatric Diagnosis, behavior modifying medications, and how those diagnosis affect the mal-adaptive behaviors. The FUBA was updated to include agitation and hyper-activity and new PBSP objectives were created for those behaviors based on the information in

the FUBA. A new sleep documentation form was instituted to document hours of sleep and incidents of restlessness and insomnia in the night. A review of the FUBA revealed that emotional outbursts for this resident consisted of verbal aggression/intimidation and physical intimidation which are both assessed on the FUBA so the behaviors will not be documented as verbal aggression/intimidation or physical intimidation rather than emotional outburst. verbal aggression The new information in the FUBA for individual #4 was used to update their Positive Behavior Support Plan (PBSP) to ensure continuity between the assessment and the interventions. Mal-adaptive sexual behaviors was added to the FUBA of individual #1 and incorporated into the PBSP and a new objective was created. The behaviors of refusing to attend school and socially offensive behaviors has been removed from the FUBA and PBSP because these behaviors have not been displayed for more than 6 months. If they occurs again it will be treated as a re-emerging behavior and will be included in the FUBA.

2. The FUBA and PBSP for all residents will be updated to include their Psychiatric Diagnosis, behavior modifying medications, and any environmental factors and how those things affect the mal-adaptive behaviors. All documented exhibited mal-adapted behaviors will be included in the FUBA and PBSP including new PBSP objectives when indicated for each resident and behaviors that have not occurred in 6 months have been removed. The new information in the FUBA for all residents will be used to update their Positive Behavior Support Plan (PBSP) to ensure continuity between the assessment and the interventions. A new sleep documentation form was instituted to document hours of sleep and incidents of restlessness and insomnia in the night for all residents to monitor for existing or new sleep issues as those residents who do not take medications to help them sleep do have differences in sleep as side effects of their medications. This will be completed by the IDT including The QMRP, the AQMRP, the LPN, the administrator, the residents, and other members as indicated.
3. The QMRP will monitor the behavior documentation monthly and will update the IPP as needed to reflect any major changes in the resident's behaviors or new or emerging behaviors based on updated FUBA.
4. These changes will be made by 3/9/2011.

**W239**

1. For individual #1, the replacement objectives were changed to require a true alternative to the mal-adaptive behaviors based on the identified functions of those behaviors in the updated FUBA.

   For individual #2, the replacement objectives were changed to require a true alternative to the mal-adaptive behaviors based on the identified functions of those behaviors in the updated FUBA.

   For individual #3, the replacement objectives were changed to require a true alternative to the mal-adaptive behaviors based on the identified functions of those behaviors in the updated FUBA.

   For individual #4, the replacement objectives were changed to require a true alternative to the mal-adaptive behaviors based on the identified functions of those behaviors in the updated FUBA.

2. All replacement objectives for all residents have been reviewed by the administrator and QMRP. Any replacement objectives that did not identify a true alternative to the mal-adaptive behavior, that did not indicate how the resident was to be trained to achieve the objective, and/or was designed as an intervention when a resident was displaying mal-adaptive behavior, were revised to reflect true replacement objectives that reflected training the resident to manage their own behaviors during times of calm.
3. All future replacement objectives are created.
4. These changes will be completed as of 3/9/10.

**W252**

1. For individuals 1-4, staff have been retrained by the administrator on information that is needed to be included on an ABC form. Specifically, this documentation must include: specific details of the behavior including number of times the behavior occurred, duration, what the behavior looked, sounded, and/or felt like, other options presented to the resident, the progression of events, the timing and progression of staff interventions and the response to staff interventions, if the interventions were successful, and if any restrictive interventions were used.
2. Staff were trained to include this information for all behavior documentation for all residents.
3. New ABC forms have been created to document behavior. This form asks detailed question designed to elicit narrative information on specific details of the behavior including number of times the behavior occurred, duration, what the behavior looked, sounded, and/or felt like, other options presented to the resident, the progression of events, the timing and progression of staff interventions and the response to staff interventions, if the interventions were successful, and if any restrictive interventions were used.
   The AQMRP will read all future ABC forms and will document any missing information on any of the forms and will use and document corrective actions taken to ensure that those mistakes do not reoccur.
4. These changes have been made as of 3/9/10.

**W262**

1. For individual #1, HRC approval will be obtained and documented for all restrictive interventions including behavior modifying medications.

   For individual #2, Trazadone was discontinued due to lack of documented need as reported on the sleep documentation. HRC approval will be obtained and documented for all behavior modifying medications currently prescribed.

   For individual #3, HRC approval will be obtained and documented for Trazadone.

   For individual #4, HRC approval will be obtained and documented for all behavior modifying medications.

2. The Administrator will review the charts of all residents and will obtain and document HRC consent for any restrictive interventions including behavior modifying medications that do not have informed consents from the HRC.
3. From this day forward, the AQMRP will ensure that verbal requests for informed consents are obtained from the HRC prior to any restrictive interventions being implemented. The Administrator will obtain written informed consent within 60 days of obtaining verbal consent. The QMRP will review the files of all residents monthly to ensure that HRC approvals are in place for all restrictive interventions and that verbal consents have not expired without written informed consents being obtained.
4. These changes have been made as of 3/16/10.

**W263**

1. For individual #1 new verbal informed consents from the parent will be obtained and we will send another request for written informed consents will be sent certified mail. The verbal informed consents will not have a 30 day expiration.

   For individual #2, Trazadone was discontinued due to lack of documented need as reported on the sleep documentation. HRC approval will be obtained and documented for all behavior modifying medications currently prescribed.

   For individual #3, parental informed consent will be obtained and documented for Trazadone.

   For individual #4 and all other residents, the QMRP will review the charts of all residents and will obtain and document parental informed consent for any restrictive interventions including behavior modifying medications that do not have informed consents from parent/guardian in place.

2. The Administrator will review the charts of all residents and will obtain and document HRC consent for any restrictive interventions including behavior modifying medications that do not have informed consents from the HRC.
3. From this day forward, the AQMRP will ensure that verbal requests for informed consents are obtained from the parents/guardian prior to any restrictive interventions being implemented. The AQMRP will send a request for written informed consent by certified mail at the time of obtaining verbal consent. The QMRP will review the files of all residents monthly to ensure that parental informed consents are in place for all restrictive interventions and that if verbal consents are in place, documentation of continued attempts to obtain written informed consents is present.
4. These changes will be made as of 3/16/10.

**W278**

1. For individual #2, The Trazadone was held while staff tried less restrictive interventions to help him sleep and documented his sleep. At the same time the Concerta was held due to the negative effects of the medication outweighing the benefits. The sleep documentation showed that the resident was able to consistently get to sleep and stay asleep and achieve the targeted amount of sleep per night without the use of Trazadone. This information was relayed to the prescribing doctor and the Trazadone was discontinued.
2. For all residents, the QMRP and LPN will ensure that documentation of less restrictive interventions that have been tried and failed is in place before new restrictive interventions have been implemented.
3. The QMRP and LPN will ensure that documentation of less restrictive interventions that have been tried and failed will be in place before new restrictive interventions are implemented.
4. These changes will be made as of 3/9/10.

**W289** - refer to the plan of correction for W239

**W303**

1. Staff responsible for incomplete restraint forms have been trained and counseled on the importance of filling out all sections of the restraint forms completely.
2. All Staff were retrained on how to fill out a restraint documentation form. Specifically they were trained that all sections of the form must be completed, that either a detailed ABC form must be attached to the restraint form or the restraint form must include all of the information that is required to be on a ABC form. (Specific details of the behavior that made the restraint necessary including number of times the behavior occurred, duration, what the behavior looked, sounded, and/or felt like, other options presented to the resident, other less restrictive interventions tried, the progression of events including what happened before, during, and after the behavior, the timing and progression of staff interventions and the response to staff interventions, if the interventions were successful. ) They were also retrained that each restraint must be documented as a different restraint on a different line with all information for each restraint filled out.
3. The QMRP will review all restraint documentation forms to ensure that they are filled out correctly. If any are not filled out correctly and/or indicate use of restraint that is not in line with the directions in the individual's PBSP, the QMRP will take corrective action and document the action taken.
4. These changes will be made as of 3/9/10.

**W312**

1. For individual #1, Medical plans of reduction have been put into place for all behavior modifying medications tied to the behaviors that they have been prescribed to treat.

For Individual #2, Medical plans of reduction have been put into place for Abilify. Concerta and Trazadone have been discontinued.

2. The LPN and QMRP review the IPP's for all residents to ensure that a medical plan of reduction is in place for all behavior modifying medications for all residents.
3. The LPN will ensure that a medical plan of reduction is in place for all behavior modifying medications for all residents. The LPN will also work with the QMRP and AQMRP to ensure that the plan of reduction is followed. The LPN will follow the new policy titled Behavior Documentation and Behavior Modifying Medication when reviewing medications with parents and doctors to ensure that medications are reduced as soon as indicated.
4. These changes have been made as of 3/9/10.

**W313**

1. Individual #2's Concerta was placed on a hold by the doctor and the IDT has determined that the negative effects of the medication do outweigh any positive benefit for the resident. (Documentation showed that the resident experienced negative personality changes and was unable to enjoy activities that he loved due to the effects of the Concerta) Therefore, although the FUBA has been amended to show that the resident's behaviors that are symptoms of his ADHD are severe and cause him to be socially isolated, inhibit his schooling options, decrease his potential for independence, and infringe on the rights of others, the LPN has informed the doctor of the documented negative effects of the medications and the IDT's recommendation that the medication be discontinued at the medication management appointment on 3/3/2011 and the Concerta was discontinued.
2. The FUBAs for all residents are being reviewed by the AQMRP, QMRP and the LPN to ensure that the negative effects of the behaviors being treated by medications are outweighed by the benefits of the medication to the resident. If the benefits do not weight the use of the behavior modifying medications, the IDT will meet to determine what action should be taken to reduce or discontinue the medications.
3. The new policy titled Behavior Documentation and Behavior Modifying Medication ensures that new behavior modifying medications will not be given unless it is determined that the benefits of the medication outweigh the potentially harmful effects of the drugs. The LPN will be responsible to ensure that the policy is followed.
4. These changes have been completed as of 3/2/2011.
5.

**MM177** - refer to the plan of corrections for W122, W149, W153, W154, and W157

**MM182** – refer to the plan of correction for W303

**MM192** – refer to the plan of correction for W278

**MM194** - refer to the plan of correction for W626 – 262

**MM196** - refer to the plan of correction for W263

**MM197** - refer to the plan of correction for W289 and W312

**MM212** - refer to the plan of correction for W266

**MM725** - refer to the plan of correction for W159

**MM729** - refer to the plan of correction forW227

**MM730** - refer to the plan of correction for W214, and W252

**MM855** - refer to the plan of correction for W239

# Home Again ICF Plan of Corrections

Signature of Administrator _____ Date: 3/2/2011

***Key:***

***QMRP – Qualified Mental Retardation Professional***
***LCSW - Licensed Clinical Social Worker***
***LPN – Licensed Practical Nurse***
***IPP – Individual Program Plan***
***FUBA – Functional Behavior Assessment***
***AQMRP – Assistant Qualified Mental Retardation Professional***
***RN – Registered Nurse***
***ABC – Antecedent, Behavior, Consequence***
***PBSP – Positive Behavior Support Plan***

1. ***Describe what corrective actions will be accomplished for those individuals found to have been affected by the deficient practice.***
2. ***Describe how the facility will identify other individuals having the potential to be affected by the same deficient practice and what corrective actions and what corrective actions will be taken.***
3. ***Describes what measures will be put into place or what systematic change will be made to ensure that the deficient practice does not reoccur. How will the corrective actions be monitored to ensure that the deficient practice will not reoccur, ie. What quality assurance program will be put into place.***
4. ***What is the date that the corrective actions will be completed?***

**W122** refer to plan of corrections for W149

**W149**

1. (1-2.) As stated in the immediate plan of correction, all staff were trained prior to working with the residents that any individual who voiced suicidal ideation or made any type of suicidal gesture would be immediately placed on suicide watch with a 1:1 arm's length staff, a scale of suicidal ideation would be completed by trained staff and the results immediately called to the Licensed Clinical Social Worker (LCSW), the LCSW would gather any additional information needed, the direct care staff would follow the directions of the LCSW to ensure the safety of the resident.
3. The RN and QMRP will be trained by the LCSW in assessment and protection of residents who have shown suicidal ideation. Our suicide policy is being amended by the administrator to ensure that residents are protected from potential dangers and that suicidal ideation is sufficiently assessed and monitored. The Administrator will monitor to ensure that any future RNs or QMRPs are trained in assessment of suicidal ideation by the LCSW.
4. These changes will have been completed as of 3/9/11.

**W153**

1. The Administrator retrained the staff members responsible for late notifications of abuse on the importance of immediate notification of any allegation of abuse or neglect.
2. All Home Again ICF staff were reminded of the Home Again ICF Abuse Policy and specifically the importance of immediate notification per the policy.
3. The QMRP will review all ABC and significant event forms to monthly to ensure that staff are following policy and that any allegations of abuse are reported and investigated. The Administrator will monitor the QMRP to ensure that this is completed. Any future instances of late notification of an abuse allegation will be investigated by the administrator and the staff member responsible will be reprimanded and retrained.
4. These changes will have been completed as of 3/16/11.

**W154**

1. The Administrator all of the investigations that occurred after July 2010 and ensure that lack of thorough documentation did not result in any harmful effects to the residents.

2. The Administrator will review all significant event forms and restraint forms to ensure that no investigations should have been conducted but were not and will complete investigations if indicated.
3. The procedure for investigations has been changed to require complete documentation of all investigations into any allegation or suspicion of abuse or neglect. This documentation includes a detailed account of the allegation, witness statements, documentation of interviews, notifications, any corrective actions taken, and the conclusion, including names and dates. The administrator will review all investigations monthly to ensure they are complete and have been thoroughly documented.
4. These changes have been made as of 3/9/11.

**W157**

1. (1-2) The QMRP and AQMRP will review all of the investigations that occurred after July 2010 and document any corrective actions that took place to correct those issues and/or make corrective actions to address any issues as indicated.
3. The investigation procedure now includes a specific place to document all corrective actions taken as a result of the investigation including a detailed account of the allegation, witness statements, documentation of interviews including what questions were asked, any corrective action taken, notifications, and the conclusion. This information will include names and dates. The administrator will review all investigations monthly to ensure they are complete and have been thoroughly documented.
4. These changes have been made as of 3/9/11.

**W159**

1. (1-2) The administrator has trained the new QMRP on the importance of consistent monitoring of behavior documentation and interventions for all residents.
3. The document titled QMRP Notes is being updated for the month of February for all residents to show the percentage of success and number of trials and any applicable comments regarding the progress of the resident. The information on mal-adaptive behaviors required in the narratives will be documented monthly in the new QMRP Notes and Behavior Documentation Form. In this form, it states the total number of incidents for all inappropriate behaviors exhibited by the resident in that month, if the inappropriate behavior is increasing or decreasing in frequency and/or severity, if a resident has met the criteria for reducing the medication tied to a specific behavior, whether the instances of each type of behavior happened evenly throughout the month or whether most instances happened during one week or day in the month, and if any patterns have been found: for example does the behavior happen most often in a specific time of day or on a specific day of the week, or during a specific activity. The AQMRP will document any new or emerging behaviors monthly and will notify the QMRP that these behaviors need to be assessed.

   The behavior tallying has been updated to include only the behaviors currently being targeted with definitions of those behaviors and new or emerging behaviors will be added to the form to ensure that all mal-adaptive behaviors that are in the residents Positive Behavior Support Plans are being monitored and that new and emerging behaviors are identified early. Any behaviors identified on the past Behavior Tally Form that are not included in the resident's FUBA and PBSP have been assessed and included in the PBSP and this will continue to happen monthly by the QMRP.

   All administrative staff have been trained in the new policy titled Behavior Documentation and Behavior Modifying Medication that has been added to the policy and procedure manual. This procedure gives detailed instructions on how mal-adaptive behaviors will be documented, monitored, and addressed. It also gives detailed instructions on how to prepare a detailed report to take to a medication management appointment. This report will include the following information: What behaviors have been documented since the last visit? How many times have the behaviors occurred? Have the instances happened throughout the month or did most happen in one day or week? If so what happened in that week or day? Have the instances of the behavior been more severe or less severe since the last visit? Is there an

assessment and plan for this behavior or is it new or emerging? What less restrictive interventions have been tried to address this behavior? Could this behavior be reduced by changing the environment? Is this behavior occurring as a reaction to a change or something happening in the resident's environment? Is there a plan in place to help the resident deal with the change? Is this change something we can control or change? Is this a change that is temporary or seasonal? Does the IDT feel that the change in behavior (s) indicates a need for a change in the medication? Has the resident met the objective set out to reduce the attending medication?

The IDT including the QMRP, AQMRP, and the LPN will assess the identified mal-adaptive behaviors documented for all residents monthly to ensure that all of the information required above is available for all of the behaviors for the month of February and in the future. This information will be included in February's updated QMRP Notes and all future QMRP notes.

A new sleep documentation form is now being used for all residents to document the number of hours the resident sleeps and incidents of restlessness or wakefulness in the night. The QMRP and LPN will monitor the documentation of the resident's sleep monthly to assess the need for any changes to the objectives or medication.

The Administrator will meet with the QMRP and LPN monthly to ensure that all of these things are being completed according to policy.

4. These changes will be made by 3/9/2011..

**W166**

1. (1-2.) As stated in the immediate plan of correction, all staff were trained prior to working with the residents that any individual who voiced suicidal ideation or made any type of suicidal gesture would be immediately placed on suicide watch with a 1:1 arm's length staff, a scale of suicidal ideation would be completed by trained staff and the results immediately called to the Licensed Clinical Social Worker (LCSW), the LCSW would gather any additional information needed, the direct care staff would follow the directions of the LCSW to ensure the safety of the resident.
3. The RN and QMRP will be trained by the LCSW in assessment and protection of residents who have shown suicidal ideation. Our suicide policy is being amended by the administrator to ensure that residents are protected from potential dangers and that suicidal ideation is sufficiently assessed and monitored. The Administrator will monitor to ensure that any future RNs or QMRPs are trained in assessment of suicidal ideation and ensuring resident safety by the LCSW within 30 days of hire and before they are able to make decisions about the safety of residents who have expressed suicidal ideation.
4. These changes will have been completed as of 3/9/11.

**W214**

1. For individual #1, the resident's functional behavior assessment (FUBA) has been updated to include their Psychiatric Diagnosis, behavior modifying medications, and how those diagnosis affect the mal-adaptive behaviors. The new information in the FUBA for individual #1 will be used to update their Positive Behavior Support Plan (PBSP) to ensure continuity between the assessment and the interventions. Mal-adaptive sexual behaviors will be added to the FUBA of individual #1 and incorporated into the PBSP. The environmental factor of moving will be removed from the IPP because the assessment showed that it is no longer a contributing factor.

   For individual #2, the resident's functional behavior assessment (FUBA) is being updated to include their Psychiatric Diagnosis, behavior modifying medications, and how those diagnosis affect the mal-adaptive behaviors. Information is being included in the FUBA for individual #2 regarding the enjoyment that this resident is observed to experience from upsetting others and trying to get others in trouble. A behavior assessment for Running Away, sexually inappropriate behaviors, physical intimidation, task avoidance, and Suicidal Ideation will be completed in the resident's FUBA. The new information in the FUBA for individual #2 will be used to update their Positive Behavior Support Plan (PBSP) to ensure continuity between the assessment and the interventions.

For individual #3, the resident's functional behavior assessment (FUBA) will be updated to include their Psychiatric Diagnosis, behavior modifying medications, and how those diagnosis affect the mal-adaptive behaviors. The FUBA will be updated to include agitation, physical intimidation, emotional outbursts (which includes verbal aggression), task avoidance, and property destruction. The resident has not demonstrated inappropriate sexual behaviors since admittance, so that behavior is no longer being monitored. If it occurs again it will be treated as a re-emerging behavior and will be included in the FUBA and PBSP. The assessment of restlessness will be broadened to include insomnia and a new sleep documentation form was instituted to document hours of sleep and incidents of restlessness and insomnia in the night. The new information in the FUBA for individual #3 will be used to update their Positive Behavior Support Plan (PBSP) to ensure continuity between the assessment and the interventions.

For individual #4, the resident's functional behavior assessment (FUBA) will be updated to include their Psychiatric Diagnosis, behavior modifying medications, and how those diagnosis affect the mal-adaptive behaviors. The FUBA will be updated to include agitation and hyper-activity. A new sleep documentation form was instituted to document hours of sleep and incidents of restlessness and insomnia in the night. A review of the ABC data revealed that emotional outbursts for this resident consisted of verbal aggression/intimidation and physical intimidation which are both assessed on the FUBA so the behaviors will not be documented as verbal aggression/intimidation or physical intimidation rather than emotional outburst. The new information in the FUBA for individual #4 will be used to update their Positive Behavior Support Plan (PBSP) to ensure continuity between the assessment and the interventions. Mal-adaptive sexual behaviors will be added to the FUBA of individual #4 and incorporated into the PBSP. The behaviors of refusing to attend school and socially offensive behaviors has been removed from the FUBA and PBSP because these behaviors have not been displayed for more than 6 months. If they occurs again it will be treated as a re-emerging behavior and will be included in the FUBA.

2. The FUBA and PBSP for all residents will be updated to include their Psychiatric Diagnosis, behavior modifying medications, and any environmental factors and how those things affect the mal-adaptive behaviors. All documented exhibited mal-adapted behaviors will be included in the FUBA and PBSP for each resident and behaviors that have not occurred in 6 months have been removed. The new information in the FUBA for all residents will be used to update their Positive Behavior Support Plan (PBSP) to ensure continuity between the assessment and the interventions. A new sleep documentation form was instituted to document hours of sleep and incidents of restlessness and insomnia in the night for all residents to monitor for existing or new sleep issues as those residents who do not take medications to help them sleep do have differences in sleep as side effects of their medications. This will be completed by the IDT including The QMRP, the AQMRP, the LPN, the administrator, the residents, and other members as indicated.
3. The QMRP will monitor the behavior documentation monthly and will update the FUBA and PBSP as needed to reflect major changes in the resident's behaviors or any new or emerging behaviors. The administrator will meet with the QMRP monthly to review paperwork and ensure that this is completed.
4. These changes will be made by 3/9/2011.

**W227**

1. For individual #2, the resident's functional behavior assessment (FUBA) will be updated to include their Psychiatric Diagnosis, behavior modifying medications, and how those diagnosis affect the mal-adaptive behaviors. Information will be included in the FUBA for individual #2 regarding the enjoyment that this resident is observed to experience from upsetting others and trying to get others in trouble. A behavior assessment for Running Away, sexually inappropriate behaviors, physical intimidation, task avoidance, and Suicidal Ideation will be completed in the resident's FUBA. An assessment of emotional outbursts revealed that it fit into the definition for tantrums which has an assessment and objective, so this behavior is now being documented as tantrum and not emotional outbursts. The new information in the FUBA for individual #2 will be used to update their Positive Behavior Support Plan (PBSP) to ensure continuity between the assessment and the interventions. New IPP objectives will be added for running Away, sexually inappropriate behaviors, physical intimidation, task avoidance, and Suicidal Ideation based on the behavior assessments for those behaviors in the FUBA.

For individual #1, the resident's functional behavior assessment (FUBA) will be updated to include their Psychiatric Diagnosis, behavior modifying medications, and the environmental factor of moving and how those diagnosis affect the mal-adaptive behaviors. The new information in the FUBA for individual #1 will be used to update their Positive Behavior Support Plan (PBSP) to ensure continuity between the assessment and the interventions. Mal-adaptive sexual behaviors will be added to the FUBA of individual #1 and incorporated into the PBSP and a new objective was created for this behavior.

For individual #3, the resident's functional behavior assessment (FUBA) was updated to include their Psychiatric Diagnosis, behavior modifying medications, and how those diagnosis affect the mal-adaptive behaviors. The FUBA was updated to include agitation, physical intimidation, emotional outbursts (which includes verbal aggression), task avoidance, and property destruction. New PBSP objectives were created for these behaviors based on the information in the FUBA. The resident has not demonstrated inappropriate sexual behaviors since admittance, so that behavior is no longer being monitored. If it occurs again it will be treated as a re-emerging behavior and will be included in the FUBA. The assessment of restlessness was broadened to include insomnia and a new sleep documentation form was instituted to document hours of sleep and incidents of restlessness and insomnia in the night. The new information in the FUBA for individual #3 was used to update their Positive Behavior Support Plan (PBSP) to ensure continuity between the assessment and the interventions.

For individual #4, the resident's functional behavior assessment (FUBA) was updated to include their Psychiatric Diagnosis, behavior modifying medications, and how those diagnosis affect the mal-adaptive behaviors. The FUBA was updated to include agitation and hyper-activity and new PBSP objectives were created for those behaviors based on the information in the FUBA. A new sleep documentation form was instituted to document hours of sleep and incidents of restlessness and insomnia in the night. A review of the FUBA revealed that emotional outbursts for this resident consisted of verbal aggression/intimidation and physical intimidation which are both assessed on the FUBA so the behaviors will not be documented as verbal aggression/intimidation or physical intimidation rather than emotional outburst. verbal aggression The new information in the FUBA for individual #4 was used to update their Positive Behavior Support Plan (PBSP) to ensure continuity between the assessment and the interventions. Mal-adaptive sexual behaviors was added to the FUBA of individual #1 and incorporated into the PBSP and a new objective was created. The behaviors of refusing to attend school and socially offensive behaviors has been removed from the FUBA and PBSP because these behaviors have not been displayed for more than 6 months. If they occurs again it will be treated as a re-emerging behavior and will be included in the FUBA.

2. The FUBA and PBSP for all residents will be updated to include their Psychiatric Diagnosis, behavior modifying medications, and any environmental factors and how those things affect the mal-adaptive behaviors. All documented exhibited mal-adapted behaviors will be included in the FUBA and PBSP including new PBSP objectives when indicated for each resident and behaviors that have not occurred in 6 months have been removed. The new information in the FUBA for all residents will be used to update their Positive Behavior Support Plan (PBSP) to ensure continuity between the assessment and the interventions. A new sleep documentation form was instituted to document hours of sleep and incidents of restlessness and insomnia in the night for all residents to monitor for existing or new sleep issues as those residents who do not take medications to help them sleep do have differences in sleep as side effects of their medications. This will be completed by the IDT including The QMRP, the AQMRP, the LPN, the administrator, the residents, and other members as indicated.
3. The QMRP will monitor the behavior documentation monthly and will update the IPP as needed to reflect any major changes in the resident's behaviors or new or emerging behaviors based on updated FUBA.
4. These changes will be made by 3/9/2011.

**W239**

1. For individual #1, the replacement objectives were changed to require a true alternative to the mal-adaptive behaviors based on the identified functions of those behaviors in the updated FUBA.

For individual #2, the replacement objectives were changed to require a true alternative to the mal-adaptive behaviors based on the identified functions of those behaviors in the updated FUBA.

For individual #3, the replacement objectives were changed to require a true alternative to the mal-adaptive behaviors based on the identified functions of those behaviors in the updated FUBA.

For individual #4, the replacement objectives were changed to require a true alternative to the mal-adaptive behaviors based on the identified functions of those behaviors in the updated FUBA.

2. All replacement objectives for all residents have been reviewed by the administrator and QMRP. Any replacement objectives that did not identify a true alternative to the mal-adaptive behavior, that did not indicate how the resident was to be trained to achieve the objective, and/or was designed as an intervention when a resident was displaying mal-adaptive behavior, were revised to reflect true replacement objectives that reflected training the resident to manage their own behaviors during times of calm.
3. All future replacement objectives will be completed by the QMRP as needed to identify a true replacement that meets the same function as the mal-adaptive behavior. The QMRP will review the IPP's at least quarterly or sooner if indicated to ensure that appropriate replacement objectives are in place for all residents.
4. These changes will be completed as of 3/9/11.

**W252**

1. For individuals 1-4, staff have been retrained by the administrator on information that is needed to be included on an ABC form. Specifically, this documentation must include: specific details of the behavior including number of times the behavior occurred, duration, what the behavior looked, sounded, and/or felt like, other options presented to the resident, the progression of events, the timing and progression of staff interventions and the response to staff interventions, if the interventions were successful, and if any restrictive interventions were used.
2. Staff were trained to include this information for all behavior documentation for all residents.
3. New ABC forms have been created to document behavior. This form asks detailed question designed to elicit narrative information on specific details of the behavior including number of times the behavior occurred, duration, what the behavior looked, sounded, and/or felt like, other options presented to the resident, the progression of events, the timing and progression of staff interventions and the response to staff interventions, if the interventions were successful, and if any restrictive interventions were used.
   The AQMRP will read all future ABC forms monthly and will document any missing information on any of the forms and will use and document corrective actions taken to ensure that those mistakes do not reoccur.
4. These changes have been made as of 3/9/11.

**W262**

1. For individual #1, HRC approval will be obtained and documented for all restrictive interventions including behavior modifying medications.

   For individual #2, Trazadone was discontinued due to lack of documented need as reported on the sleep documentation. HRC approval will be obtained and documented for all behavior modifying medications currently prescribed.

   For individual #3, HRC approval will be obtained and documented for Trazadone.

   For individual #4, HRC approval will be obtained and documented for all behavior modifying medications.

2. The Administrator will review the charts of all residents and will obtain and document HRC consent for any restrictive interventions including behavior modifying medications that do not have informed consents from the HRC.

3. From this day forward, the AQMRP will ensure that verbal requests for informed consents are obtained from the HRC prior to any restrictive interventions being implemented. The Administrator will obtain written informed consent within 60 days of obtaining verbal consent. The QMRP will review the files of all residents monthly to ensure that HRC approvals are in place for all restrictive interventions and that verbal consents have not expired without written informed consents being obtained.
4. These changes have been made as of 3/16/11.

**W263**

1. For individual #1 new verbal informed consents from the parent will be obtained and we will send another request for written informed consents will be sent certified mail. The verbal informed consents will not have a 30 day expiration.

   For individual #2, Trazadone was discontinued due to lack of documented need as reported on the sleep documentation. HRC approval will be obtained and documented for all behavior modifying medications currently prescribed.

   For individual #3, parental informed consent will be obtained and documented for Trazadone.

   For individual #4 and all other residents, the QMRP will review the charts of all residents and will obtain and document parental informed consent for any restrictive interventions including behavior modifying medications that do not have informed consents from parent/guardian in place.

2. The Administrator will review the charts of all residents and will obtain and document HRC consent for any restrictive interventions including behavior modifying medications that do not have informed consents from the HRC.
3. From this day forward, the AQMRP will ensure that verbal requests for informed consents are obtained from the parents/guardian prior to any restrictive interventions being implemented. The AQMRP will send a request for written informed consent by certified mail at the time of obtaining verbal consent. The QMRP will review the files of all residents monthly to ensure that parental informed consents are in place for all restrictive interventions and that if verbal consents are in place, documentation of continued attempts to obtain written informed consents is present.
4. These changes will be made as of 3/16/11.

**W266 - See W278, W289, W303, W312, and W313**

**W278**

1. For individual #2, The Trazadone was held while staff tried less restrictive interventions to help him sleep and documented his sleep. At the same time the Concerta was held due to the negative effects of the medication outweighing the benefits. The sleep documentation showed that the resident was able to consistently get to sleep and stay asleep and achieve the targeted amount of sleep per night without the use of Trazadone. This information was relayed to the prescribing doctor and the Trazadone was discontinued.
2. For all residents, the QMRP and LPN will ensure that documentation of less restrictive interventions that have been tried and failed is in place before new restrictive interventions have been implemented.
3. The QMRP and LPN will ensure that documentation of less restrictive interventions that have been tried and failed will be in place before new restrictive interventions are implemented.
4. These changes will be made as of 3/9/11.

**W289**

1. For individual #1, the replacement objectives were changed to require a true alternative to the mal-adaptive behaviors based on the identified functions of those behaviors in the updated FUBA and new training data sheets have been created to instruct on how to train the resident in those replacement behaviors.

For individual #2, the replacement objectives were changed to require a true alternative to the mal-adaptive behaviors based on the identified functions of those behaviors in the updated FUBA, and new training data sheets have been created to instruct on how to train the resident in those replacement behaviors.

For individual #3, the replacement objectives were changed to require a true alternative to the mal-adaptive behaviors based on the identified functions of those behaviors in the updated FUBA and new training data sheets have been created to instruct on how to train the resident in those replacement behaviors..

For individual #4, the replacement objectives were changed to require a true alternative to the mal-adaptive behaviors based on the identified functions of those behaviors in the updated FUBA and new training data sheets have been created to instruct on how to train the resident in those replacement behaviors.

2. All replacement objectives for all residents have been reviewed by the administrator and QMRP. Any replacement objectives that did not identify a true alternative to the mal-adaptive behavior, that did not indicate how the resident was to be trained to achieve the objective, and/or was designed as an intervention when a resident was displaying mal-adaptive behavior, were revised to reflect true replacement objectives that reflected training the resident to manage their own behaviors during times of calm and new training data sheets have been created to instruct on how to train the resident in those replacement behaviors.
3. All future replacement objectives will be completed by the QMRP as needed to identify a true replacement that meets the same function as the mal-adaptive behavior. The QMRP will review the IPP's at least quarterly or sooner if indicated to ensure that appropriate replacement objectives are in place for all residents and new training data sheets will be created to instruct on how to train the resident in those replacement behaviors.
4. These changes will be completed as of 3/9/11.

**W303**

1. Staff responsible for incomplete restraint forms have been trained and counseled on the importance of filling out all sections of the restraint forms completely.
2. All Staff were retrained on how to fill out a restraint documentation form. Specifically they were trained that all sections of the form must be completed, that either a detailed ABC form must be attached to the restraint form or the restraint form must include all of the information that is required to be on a ABC form. (Specific details of the behavior that made the restraint necessary including number of times the behavior occurred, duration, what the behavior looked, sounded, and/or felt like, other options presented to the resident, other less restrictive interventions tried, the progression of events including what happened before, during, and after the behavior, the timing and progression of staff interventions and the response to staff interventions, if the interventions were successful. ) They were also retrained that each restraint must be documented as a different restraint on a different line with all information for each restraint filled out.
3. The QMRP will review all restraint documentation forms to ensure that they are filled out correctly. If any are not filled out correctly and/or indicate use of restraint that is not in line with the directions in the individual's PBSP, the QMRP will take corrective action and document the action taken.
4. These changes will be made as of 3/9/11.

**W312**

1. For individual #1, Medical plans of reduction have been put into place for all behavior modifying medications tied to the behaviors that they have been prescribed to treat.
   For Individual #2, Medical plans of reduction have been put into place for Abilify. Concerta and Trazadone have been discontinued.

2. The LPN and QMRP review the IPP's for all residents to ensure that a medical plan of reduction is in place for all behavior modifying medications for all residents.
3. The LPN will ensure that a medical plan of reduction is in place for all behavior modifying medications for all residents. The LPN will also work with the QMRP and AQMRP to ensure that the plan of reduction is followed. The LPN will follow the new policy titled Behavior Documentation and Behavior Modifying Medication when reviewing medications with parents and doctors to ensure that medications are reduced as soon as the criteria has been met as outlined in the medical plans of reduction unless indicated by the IDT.
4. These changes have been made as of 3/9/11.

**W313**

1. Individual #2's Concerta was placed on a hold by the doctor and the IDT has determined that the risk of the behaviors treated by the medication did not outweigh the harmful side effects of the medication. (Documentation showed that the resident experienced negative personality changes and was unable to enjoy activities that he loved due to the effects of the Concerta) Therefore, although the FUBA has been amended to show that the resident's behaviors that are symptoms of his ADHD are severe and cause him to be socially isolated, inhibit his schooling options, decrease his potential for independence, and infringe on the rights of others, the LPN has informed the doctor of the documented negative effects of the medications and the IDT's recommendation that the medication be discontinued at the medication management appointment on 3/3/2011 and the Concerta was discontinued.
2. The FUBAs for all residents are being reviewed by the AQMRP, QMRP and the LPN to ensure that risk of behavior outweighs the potential harm from the medications. If the risk of behaviors do not weight the potential harm of the behavior modifying medications, the IDT will meet to determine what action should be taken to reduce or discontinue the medications.
3. The new policy titled Behavior Documentation and Behavior Modifying Medication ensures that new behavior modifying medications will not be given unless it is determined that the risk of behavior outweighs the potential harm from the medications. The LPN will be responsible to ensure that the policy is followed.
4. These changes have been completed as of 3/2/2011.

**MM177** - refer to the plan of corrections for W122, W149, W153, W154, and W157

**MM182** – refer to the plan of correction for W303

**MM192** – refer to the plan of correction for W278

**MM194** - refer to the plan of correction for W626

**MM196** - refer to the plan of correction for W263

**MM197** - refer to the plan of correction for W289 and W312

**MM212** - refer to the plan of correction for W266

**MM725** - refer to the plan of correction for W159

**MM729** - refer to the plan of correction forW227

**MM730** - refer to the plan of correction for W214, and W252

**MM855** - refer to the plan of correction for W239